Healthy Outcomes Plan Application

Proviso

33.34

Sections A (1), C, D

South Carolina Department of Health and Human Services

Hospital(s): Trident Health

HOP Name: Trident Health Community Care Network

Healthy Outcomes Plan (HOP) Application

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

Application Cover Page

HOP Name	Trident Health Community Care Network
Application Date	August 30, 2013
Name of Hospital(s)	Trident Health
Name of Partner(s)	Trident Family Health

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.

Michael Gingras
CFO, Trident Health
Hospital Representative

8/29/2013
Date

Robert Faile
Division VP, HCA Physician Services
Partner Representative

8/28/13
Date

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

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LETTER OF INTENT TO COLLABORATE BETWEEN
Trident Health and Trident Family 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 Emergency Department (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:	Trident Health
Name and Title:	Michael Gingras, CFO
Date:	August 29, 2013

Institution:	Trident Family Health
Name and Title:	Robert Faile, HCA Physician Services Division VP
Date:	August 29, 2013

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HOP Application Form

Hospital	Trident Medical Center, LLC (dba Trident Health, Trident Medical Center, Summerville Medical Center) Trident Health is an accredited two hospital system comprised of the 296-licensed bed Trident Medical Center and the 94-licensed bed Summerville Medical Center located in North Charleston and Summerville, respectively. The health system also includes one 8-bed free-standing emergency department located in Monks Corner. In 2012, the health system served more than 260,000 patients including 111,881 individuals treated in its emergency departments. Trident Health is recognized by The Joint Commission as a Top Performer on Key Quality Measures for heart attack, heart failure, and pneumonia.
Partner(s)	Trident Family Health (TFH) is a medical residency-based family medicine clinic providing a full range of services including chronic medical disease management, preventative health care, and urgent care for adults and children. TFH is staffed by 30 MUSC family medicine residents and 18 attending physicians. TFH predominantly cares for uninsured and underinsured people. The clinic currently serves as an informal referral source for Trident Health and is listed as one of the potential medical homes for unfunded patients for follow-up after being treated in one of the Trident Health ED's. Trident Health and TFH are owned by the same parent company, Hospital Corporation of America (HCA).
Partner(s) Lead(s)	Debra Morgenweck Market Practice Manager HCA Physician Services 9221 University Blvd., Suite 102 Charleston, SC 29406 (843)576-0705 Debra.Morgenweck@HCAHealthcare.com Diana Hall Practice Manager Trident Family Health 9228 Medical Plaza Dr. Charleston, SC 29406 (843)574-2290 Diana.Hall@HCAHealthcare.com
HOP Implementation Sites	Trident Medical Center 9330 Medical Plaza Drive Charleston, SC 29406 Summerville Medical Center 295 Midland Parkway Summerville, SC 29485

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	Monks Corner Medical Center 401 North Live Oak Drive, Hwy 17A Monks Corner, SC 29461 Trident Family Health 9228 Medical Plaza Drive Charleston, SC 29406
Clinical Lead	Robert Mallin, MD Professor Associate Chair For Education Department of Family Medicine Medical University of South Carolina Program Director MUSC/Trident Family Medicine Residency 9228 Medical Plaza Drive Charleston, South Carolina 29406 Office: 843-876-7083 mallinr@musc.edu
Administrative Lead	Michael Gingras CFO Trident Health 9330 Medical Plaza Dr. Charleston, SC 29406 (843)847-4100 Michael.Gingras@HCAHealthcare.com
Name of HOP	Trident Health Community Care Network
Background and Rationale Maximum 1,000 words	Trident Health primarily serves a three county area including Dorchester, Berkeley, and Charleston Counties. According to the United States Census Bureau, the 2012 estimated combined population of these three counties was 691,498 people, the estimated combined median household income was $54,875, and a combined average of 14.3% of this population was below the poverty level. Additionally, 10.5% of the population received food stamps or SNAP benefits, 3.1% received supplemental security income, and 1.6% received cash public assistance income (these percentages represent an average of the combined census data from each county). From a health care perspective, approximately 20% of the combined population in Dorchester, Berkeley, and Charleston Counties was uninsured according to the USC Institute for Families in Society and 15% of Trident Health's patients (including inpatient admissions and outpatient registrations) were uninsured or charity care patients. Five hundred six (506) unique individuals have been identified who were uninsured, presented with primary diagnosis of chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), hypertension, or diabetes, and utilized one of the three Trident Health emergency departments at least two times between April 1, 2012 and March 31, 2013. Due to other collaborative efforts by Trident Health,

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	including an established relationship with Access Health in the Charleston area, patients seen during the above mentioned time period were already being redirected to TFH. One hundred seven (107) patients were referred as a result of these efforts. Therefore, the number of ED visits was reduced to two (2) to achieve the panel size required by the state of 307 engaged participants. Analysis of this patient population of 506 potential participants indicates 42% (214) reside within Dorchester County, 38% (194) reside within Berkeley County, and 12% (62) reside within Charleston County. The USC PRMM Environmental Scan indicates patients in the above primary service areas have a moderate to high incidence of COPD and low to moderate incidence of CVD, diabetes, and hypertension. These chronic conditions contribute to over-utilization of high cost emergency room services if not properly managed. Environmental scan data also indicates hospital and clinic locations are found primarily in the Charleston County area with only one hospital located in Dorchester County and no hospital presence in Berkeley County. Additionally, while Charleston County is home to a number of Federally Qualified Health Centers, Rural Health Clinics, Free Clinics, and Welvista Clinics, the USC PRMM Environmental Scan indicated only 19 such clinics serve the densely populated urban areas of Dorchester and Berkeley Counties. In evaluating non-South Carolina Social Determinants of Health studies, we found the high utilization of emergency services results from interacting social determinants of health, including poor access to local health care, lack of private or public transportation, and large gaps in basic human needs (i.e., food and shelter) which can serve as barriers to healthcare access. This will be verified once we complete the Social and Cultural Determinants of Health Assessments. The overall desired outcome of this plan is to create a sustainable service delivery model that will maximize linkage of uninsured, high utilizers of emergency department services with targeted chronic conditions to a medical home at TFH. By partnering with community outreach organizations, Trident Health and TFH will further improve the health status and patient experience, while lowering the cost of care.
Targeted Population and Inclusion Data Maximum 1,000 Words	The population was structured by total medical condition, health care cost, and utilization. As such, the targeted population for this Healthy Outcomes Plan includes individuals who were uninsured, presented with primary diagnosis of COPD, CVD, hypertension, or diabetes, and utilized one of the three Trident Health emergency departments at least two times between April 1, 2012 and March 31, 2013. As previously indicated, patients seen during the above mentioned time period were already being redirected to TFH due to other collaborative efforts undertaken by Trident Health, including an established relationship with Access Health in the Charleston area. Therefore, the number of ED visits was reduced to two (2) to achieve the panel size required by the state of 307 engaged participants. Internal data accumulated and housed within the HCA Electronic Data Warehouse

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	was used to select the patients targeted for this plan. Data was extracted and analyzed to ensure only those patients meeting the Proviso requirements were selected. Specifically, a detailed list of all patients treated at one of the three emergency departments from April 1, 2012 thru March 31, 2013 was obtained. Patients who presented with insurance were then removed. The remaining list was further reduced to include only those patients who had visited the ED two or more times during the indicated timeframe. Clinical characteristics of the targeted population include chronic COPD, CVD, hypertension, and/or diabetes. Data indicates the targeted population also share a number of social and demographic characteristics including the following: • Age: 86% between the ages 20 and 60 • Race: 55% identified as "white" and 42% identified as "black" • Gender: 54% identified as female and 46% identified as male • Marital status: 55% indicated a status of single, 26% indicated a status of married, and 12% indicated a status of divorced The targeted sample represents approximately 61% of the estimated total population meeting the program's requirements.
Strategic Objectives	The Trident Health Community Care Network program aims to accomplish the following strategic objectives: • Increase provision and utilization of comprehensive, routine primary care • Reduce ED utilization • Improve patient access to and utilization of quality, affordable care • Establish a medical home • Promote adherence to clinical, evidenced-based guidelines
Strategic Measures	The data gathered will provide the following metrics: • Percent of successful contact with target population within 30, 60, 90 days of program • Percent target population with Social Determinants Screening within first 30, 60, 90 days of program enrollment • Percent target population connected to one or more community services as a result of Social Determinants Screening • Percent target population established with a medical home (primary care physician) and type of encounter • Percent of target population with a Health Affordability Programs Eligibility Screening • ED utilization rate • The historical cost of providing care for panel participants in the ED setting as compared to providing care in the patient medical home setting • Percent adherence to recognized clinical protocols for each chronic

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	condition, including but not limited to an initial preventative physical exam, diabetes screening tests, cardiovascular screening blood tests, tobacco use cessation counseling, blood pressure screening, and medical nutrition therapy.
Description of HOP Maximum 1,000 Words	After establishing the target population of 500 plus patients, patients will be contacted through a variety of telephonic, targeted mail, and alternative means and invited to participate in a free health screening at TFH to confirm the 307 required patient population is obtained. If potential participants express interest in participation but decline due to lack of transportation, transportation to the TFH clinic will be offered. Upon arrival at TFH, patients will meet with a Medical Resident Physician, who will perform the initial health screening, and the Patient Care Coordinator, who will perform the Social Determinants of Health Assessment. Based on the outcomes of the assessment, coupled with information from Charity Tracker (a web-based application that allows organizations to collaborate and share information on benevolence and the Benefit Bank (a web-based service used to help low income individuals and families gain access to public benefit programs), referrals will be provided to community outreach programs. Patient data including the results of the health screening, the results of the Social Determinants of Health Assessment, and referrals to community outreach programs, will be entered into a centralized database to allow for appropriate tracking and monitoring. Charity Tracker will also be used to identify patients successfully connected to a community outreach program. This information will be entered into the centralized database for tracking and reporting as well. Reporting will be performed in compliance with the Healthy Outcomes Plan guidelines. Patients utilizing Trident Health ED services will be directed to a Patient Navigator prior to discharge. The Patient Navigator will screen patients for enrollment in the Trident Health Community Care Network program. The enrollment information will be communicated to TFH for follow-up outreach. TFH will utilize the Phytel Population Health Management Solution. Phytel provides healthcare organizations with proven health technology to deliver timely, coordinated care to their patients. This technology uses evidence-based chronic and preventative care protocols to identify and notify patients due for care while providing the provider with tracking of provider and patient compliance. All patients within the targeted population will be screened for eligibility in Medicaid and other health programs via an eligibility vendor within 30 days of implementation and again within the first 90 days of the start of 2014. This proposed service delivery model will improve the health of targeted patients and decrease the incidence of inappropriate ED utilization through increased access to medical care, proactive management of chronic conditions, and linkage to community support services. This model will lower the health system's overall patient care costs by directing patients to receive care in a lower cost, non-emergent care setting and by providing proactive care management of a patient's chronic

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	conditions, thereby reducing the likelihood of a more costly hospital visit.
Resources Required for Implementation of HOP Maximum 1,000 Words	Trident Health is comprised of two hospitals, located in North Charleston and Summerville, and a free-standing ED in Moncks Corner. Trident Health provides Level III emergency care and a Level II nursery. A full range of acute care services is offered including diagnostic, critical care, neurological, obstetric, pediatric, bariatric surgery, therapy, and outpatient burn services. Award winning care is available at the fully accredited Trident Cancer Center, Certified Chest Pain Center, heart failure clinic, and Advanced Primary Stroke center. The 492 physicians on Trident Health's medical staff cover a complete range of specialties. Trident Health has contractual relations with Palmetto Lowcountry Behavioral Health and partners with a hospitalist/OB hospitalist practice and with hospital-based pathology, radiology, neurology and emergency care practices as well as EMS services from all regional EMS providers. TFH is staffed by 30 MUSC family medicine residents and 18 attending physicians and provides primary care clinic services to the community, including those who are uninsured and underinsured. TFH uses eClinical Works (eCW) as the practice management system which houses patient demographic and appointment information. Visit notes and visit-specific documentation are maintained in Medinformatics, the Electronic Medical Record system. Anticipated resources for Trident Health include salary and benefits for one added full time employee serving as the ED patient navigator at Trident Medical Center who will identify program participants and refer patients to an appropriate medical home. Additionally, anticipated resources for TFH include the following: • Salary and benefits for one added full time employee serving as the Patient Care Coordinator who will be responsible for the coordination of care of panel participants through referrals to appropriate medical services if not provided by TFH and linking patients to community outreach programs • Potential overhead costs associated with extended office hours in the evenings and Saturdays at TFH. The need/demand for extended hours will be evaluated • Contract costs associated with a telecommunications company who will be responsible for initial contact with panel participants • Contract costs associated with a third-party eligibility screening vendor who will be responsible for screening panel participants for eligibility in Medicaid and other Health Affordability plans • Staff time costs related to training/education of program objectives, the use of The Benefit Bank, Charity Tracker, and other centralized databases used for the accumulation and analysis of patient information, as well as staff

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	costs related to development and implementation of the program • Contracted hours for the program manager who will be responsible for oversight and implementation of the program, monitoring of outcomes, and continuous process improvement. • Transport costs for patients without access to transportation.
Reporting Capacity	Tracking and reporting of panel participant data will be performed at TFH. TFH uses eClinical Works (eCW) as the practice management system which houses patient demographic and appointment information. This system has reporting capabilities in which data can be extracted, trended, and analyzed. Visit notes and visit-specific documentation are maintained in Medinformatics, the Electronic Medical Record system which also has robust reporting capabilities. Additionally, a centralized database or tool will be required to allow for appropriate tracking and monitoring. With both the applicant and the partner supported by comprehensive health information systems, issues regarding the ability to provide suitable and meaningful data for evaluating the progress of this program are not anticipated.
Performance Period	October 1, 2013 to June 30, 2014