South Carolina Health & Human Services

Healthy Outcomes Plan Cover Page

Proviso 33.34 A(1), C, D

Project Title	Application Date
Healthy Outcomes Williamsburg	8/15/13

Name of Hospital(s) [1]

Williamsburg Regional Hospital

Name of Hospital(s) [2

Name of Partner(s) [1]

Williamsburg Regional Hospital Health Center

Name of Partner(s) [2]

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
Sharon Poston, CEO	8/15/13
Hospital Representative	Date
Bambi Floyd, CNO	8/15/13
Hospital Representative	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

Williamsburg Regional Hospital _____ and Williamsburg Regional Hospital Health 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, 2013, 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: Williamsburg Regional Hospital _____
Name and Title: Sharon Poston, CEO _____
Date: 8/15/13 _____

Institution: Williamsburg Regional Hospital _____
Name and Title: Bambi Floyd, CNO _____
Date: 8/15/13 _____

Institution: Williamsburg Regional Hospital Health Center _____
Name and Title: Juanita Jefferson _____
Date: 8/15/13 _____

South Carolina Health & Human Services

Healthy Outcomes Plan Application

Proviso 33.34 A(1), C, D

Name of Hospital

Williamsburg Regional Hospital

Partner(s') Leads

Williamsburg Regional Hospital Health Center – Juanita Jefferson

Name of Partner(s)

Williamsburg Regional Hospital Health Center
500 Thurgood Marshall Hwy, Suite F
Kingstree, SC 29556

Williamsburg Regional Hospital Health Center is a provider-based rural health center owned by Williamsburg Regional Hospital. There is no existing collaboration between Williamsburg Regional Hospital and Williamsburg Regional Hospital Health Center.

HOP Implementation Sites

Williamsburg Regional Hospital
500 Nelson Blvd
Kingstree, SC 29556

Williamsburg Regional Hospital Health Center
500 Thurgood Marshall Hwy, Suite F
Kingstree, SC 29556

Clinical Lead	Telephone	Email

Administrative Lead	Telephone	Email

Background and Rationale (max. 1,000 words)

The environmental scan provided by the Department of Health and Human Services clearly shows that Williamsburg County is a rural community that falls into the Palmetto SADI High Deprivation Areas and is one of many Adult Disease Hot Spots. While this facility has grown over the past two years, it still has a long way to go in order to provide this county with access to dependable, affordable, and accessible health care and keep patients in their own community. The following address the on-going problems that limit the Williamsburg County community from health care and contribute to high utilization of the Emergency Department:

- Williamsburg County unemployment rates rank above the state average (Williamsburg County ranges from 11% to 17% compared to a state average of 8% to 12%)
- EMS capabilities are limited to "the only game in town", meaning it is an agency with only four ambulances in service to cover a county of >900 square miles, compared to Florence County that has <900 square miles and an EMS service that has over 16 ambulances, along with multiple transport services that respond to 911 calls
- Williamsburg County does not have any 24-hour pharmacy services
- Few primary care physicians; i.e., three practices located in the city of Kingstree for a population of approximately 34, 423 people (as of 2012)
- No OB/GYN services available in a county that ranks in in the top 25% of the state (out of 46 counties for SC) for Syphilis, Gonorrhea, Chlamydia, & HIV (information obtained from the SCDHEC website)
- Limited access to dental services
- With 28% of ED visits in South Carolina pertaining to behavioral health problems, there is one mental health agency, Waccamaw Mental Health, and currently they have no physician on staff. The patients are referred to the ED for evaluation and treatment. Behavioral Health is also the 5th most common condition seen in the uninsured for Williamsburg County and the 6th most costly chronic condition.

As you can see by the above statistics related to primary care, a county the size of Williamsburg has very limited access; therefore, the Williamsburg Regional Hospital (WRH) Emergency Department is their primary care access. An example of the ED being used as the primary care provider is behavioral health patients. For the month of June and July, 2013, WRH ED had at least one psychiatric patient being housed in the ED for 48 out of 61 days. This not only puts a financial strain on the hospital, but a resource strain as well. The hospital does not have psychiatric services available for these patients, therefore, the patients are not getting the services they need and deserve.

In addition to behavioral health problems, Williamsburg County has an obesity rate of 65.5% with the state being at 65.85% (taken from a Williamsburg County, 2011 disease fact sheet) which compounds overall rates of diabetes and heart disease. Due to the lack of limited resources in this rural community and risk factors such as smoking, sedentary lifestyles, high fat diet, and a poor population, the target population will continue to increase if interventions such as the Healthy Outcomes Plan is not implemented in this community.

Diabetes and heart disease are chronic conditions and cannot be treated effectively in the Emergency Department. This is not only a problem for the patient, but a huge financial burden for health systems, especially at Williamsburg Regional Hospital where resources are already limited and stretched beyond current capacity and capabilities.

It is time for Williamsburg County to move forward in collaboration with all health and community agencies in the county to educate the targeted population concerning lifestyles changes that will affect the overall health and well-being of the patient population. This is the first step in improving overall health care and decreasing the continued use of the Emergency Department for primary care which will ultimately decrease the financial burden of the institution.

Target Population and Inclusion Criteria

The collaborative team will identify the target population by querying uninsured patients, grouping by targeted chronic illnesses, and limiting to patients with visits to the ED within the targeted time frame. From that group, the team will narrow the search to patients that have been seen at least 3 times within the targeted time frame, for one of the chronic illnesses, or for a problem related to that chronic illness (ex: if the patient has a diagnosis of Diabetes, the team will also look for Hyperglycemia or Hypoglycemia, Diabetic Neuropathy, Diabetic wounds/infections, etc). This panel of patients will be screened for Health Affordability programs and Medicaid eligibility, and a social determinants and behavioral health screen will be completed on each panel patient.

The population being targeted shares the following clinical and/or social characteristics:

Clinical Characteristics:

- All patients have Asthma/COPD, Hypertension, Diabetes, and/or a Behavioral Health diagnosis (Asthma is the most common diagnosis, and is the most costly diagnosis among the ED's uninsured population [costing $199,054 per year, and averaging $2727 per patient], followed closely by Behavior Health [costing $106,932 per year, and averaging $1671 per patient, as well as decreasing the 6 bed ED's capacity and efficiency – on average, the ED has at least one psych hold 3 out of every 4 days], then Hypertension, and Diabetes. COPD, Hypertension, Diabetes, and Behavior Health are also four of the most prevalent chronic diseases in Williamsburg County)
- Many patients in the targeted population have more than one of the above diagnoses
- Many patients have multiple visits to the ED, not only for the chronic illness and related problems, but for other non-emergent problems, indicating they use the ED for their primary source of medical care
- Several patients in the targeted population were seen in the ED for STDs, putting them at risk for contracting HIV (another of the targeted chronic illnesses)

Social Characteristics:

- All patients are between the ages of 18 and 60 years old
- All patients are uninsured (23% of Williamsburg County residents are uninsured, compared to a state average of 20%)
- Many patients are either unemployed or work for minimal wages with no medical benefits (unemployment rates for Williamsburg County have ranged from 11% to 17% in the past 2 years, compared to a state average of 8% to 12%)
- Many patients are at or below poverty level (33% of Williamsburg County residents are below the poverty level, which is double the state average of 17%)
- Many patients are women of childbearing age
- Many patients did not complete high school (only 78% of Williamsburg County residents over the age of 25 completed high school, compared to a state average of 84%)
- Several patients have been seen in the ED for substance abuse related problems

The group of patients included in the panel represents approximately 65% of the patient population meeting the program's criteria. The team will pull additional patients from the remaining 35% as needed to meet the program's patient panel requirements.

Strategic Objectives

In keeping with the Triple Aim service model, the coordinated care initiative between Williamsburg Regional Hospital and the Williamsburg Regional Hospital Health Center aims to improve patient care, expand access to a primary medical home, and decrease health care expenditures. It is the aim of the collaborative to place patients into a medical home to properly and more efficiently treat chronic illness. The following strategic objectives will be measured to determine success of the initiative.

1. Reduce ED utilization for chronic disease management
2. Establish a primary medical home
3. Improve access to community service networks through the identification of needs and response with appropriate referral
4. Expand access to quality, affordable, and effective healthcare coverage as a result of the Health Affordability Programs Eligibility Screening
5. Provide patients with an individualized Patient Care Plan framed by the psychosocial approach including a behavioral and Mental Health Assessment and Social Needs Assessment
6. Promote preventative primary care increasing the utilization of routine screenings
7. Provide evidence-based care that is disease specific and culturally competent
8. Provide each patient with a social determinants screening to define environmental factors influencing healthcare status and access to care
9. Minimize financial loss in the Emergency Department
10. Increase communication between providers in transition of care
11. Educate the public about the importance of establishing a medical home
12. Reduction and prevention of tobacco use through evidence-based education, referral, and treatment options

Strategic Measures

Care Metrics

- % of patient panel contacted within the first 30, 60, and 90 day measurement periods
- % of patient panel to establish a relationship with the collaborative facility for primary care management within 30, 60, and 90 days of initiation of program
- % of patients with at least 1 follow up visit after medical home establishment
- % of patients receiving social determinants screening within the first 30 and 60 days of program
  - -% of patients referred to a community service agency based on findings of social determinant screening
  - -% of patients in patient panel aligned with a patient medication assistance program after establishment of a medical home based on findings of social determinants screening
  - % of patients referred to mental health or substance abuse program after establishment of a medical home
- Number of patient encounters documented after program initiation including telephone and face-to-face visits with type of encounter documented
- % of patients
- % of patients screened for Health Affordability Program eligibility
  - -% of patients enrolled in Medicaid as a result of Health Affordability Program screening
  - -% of patients enrolled in a program other than Medicaid as a result of Health Affordability screening
- % of patients receiving smoking cessation education and resources as needed per screening
- % of patients receiving diet modification education and resources as deemed necessary according to diagnosis
- % of patients establishing a medical home receiving referral for preventative screenings and interventions
  - -Examples: Vaccine, Colonoscopy, Mammogram
- % of patients receiving information on the importance of a medical home

Cost Metrics

- ED financial loss
- ED utilization
- Overall per patient cost

- Panel admission rate

Health Metrics

- Medication compliance
- Medication reconciliation at transition of care
- Hgb A1C
- Weight measurement
- Completion of patient specific education
  - Smoking cessation
  - Diabetic education
  - Diet modification
- Blood pressure measurement

Description of HOP (max. 1,000 words)

In an effort to provide and better serve the patient population of Williamsburg County, Williamsburg Regional Hospital is proposing a collaborative health care plan. As earlier identified, Williamsburg County services a large patient population who are uninsured (5,966) or fall below poverty level (32.8%). The hospital's plan will include partnering with Williamsburg Regional Hospital Health Center. The collaborative team has determined through data collection and review that the patient population that will be most impacted through this initiative will be Mental Health, COPD, HTN and Diabetic Patients that have had repetative visits to the ED due to the lack of a medical home. It has also been identified that this particular patient population frequents the ED due to lack of insurance, limited financial resources and knowledge deficits regarding health related issues.
In order to accomplish this goal, Williamsburg Regional Hospital will provide this patient population with the tools and resources, such as a medical home, needed to better manage their health care needs. A list of qualifying patients has been compiled. The panel will be contacted to seek their agreement to participate in this initiative. Following their consent, the following actions will occur:

1. A medical home will be established.
2. Screenings will be completed by a Medicaid Coordinator and a Certified Application Counselor to determine the patient's eligibility for Medicaid and/or other Affordable Health Programs.
3. A Social Determinants screening will be performed, and appropriate community service referrals will be made (e.g. housing assistance, food assistance, elder protection services and public transportations).
4. A behavioral health assessment will be completed.
5. An individualized plan of care will be developed for each participant.
6. Evidence based guidelines will be established to encourage provider adherence to this program.

The proposed plan will assist in improving the health of this target group by:

1. Establishing a medical home where the patient can be evaluated and treated by a health care provider that is familiar with the individual's.
2. Provide the target group of patients with medical services through the Williamsburg Regional Hospital Health Center.
3. Provide the target group with individualized health care plans.
4. Expand access to quality, affordable, and effective health care.
5. Promote preventive and follow up care and treatments.
6. Provide much needed health education for the target population.

The plan will have a positive impact on ED utilization by decreasing the use of the ED as a medical home by patients that are uninsured and do not have an established medical provider by:

1. Providing affordable quality health care to the targeted group.
2. Educating the public on the importance of a medical home.
3. Providing assistance and referrals for both social determinants and health care needs.
4. Promoting preventive measures for disease processes.
5. Improving access to community service networks.

The plan will lower the hospital's overall costs by:

1. Decreasing the overall number of level (1) and (2) patients being seen in the ED, which in turn will have a direct impact on the hospitals overall costs. Data indicates the total cost incurred by the institution for the treatment of a level (1) patient is at minimum 255.70 dollars and 446.30 dollars for a level (2) patient. Williamsburg Regional Hospital Health Center patient fees average 130.00 dollars per patient visit. Although these fees will be waived for this target group, this initiative will decrease the hospitals overall patient costs for level (1) patients by 125.00 dollars per visit and 316.30 dollars for each level (2) patient visit.

The aim of this plan is not only to reduce costs incurred by the hospital, but provide a medical home and high quality medical care to a patient population greatly in need of health care.

Resources Required for Implementation of HOP

Currently Williamsburg Regional Hospital is a 25 bed critical access hospital. Our services include:

- Emergency Services
- Inpatient Acute Care
- Inpatient Skilled Care (Swing Bed)
- Intensive Care Unit
- Surgical Services including General, Orthopedic, Cardiovascular, Urological, Gastrointestinal and Podiatry Surgery
- Cardiopulmonary Services including EKG, Echocardiography, Pulmonary Function Studies and Stress Testing
- Cardiology
- Radiology including Ultrasound, Mammography, Bone Density Scanning, CT and Nuclear Medicine
- Day Hospital which includes Wound Care and a GI Lab
- Laboratory Services
- Sleep Lab providing Nerve Conduction Studies, EEGs and Sleep Studies
- Health Screenings which include cholesterol, blood pressure and blood sugar

The hospital also owns:

- Williamsburg Surgical Services consisting of Cardiovascular Surgery
- Williamsburg Regional Hospital Health Center
- Williamsburg Regional Hospital Specialty Center consisting of a Nephrology, Outpatient Wound Care, Orthopedic, GI and Allergy Clinics

Williamsburg County provides emergency medical transport service (not owned by the hospital) for the county with only four ambulances. A private emergency medical transport service operating 14 ambulances also provides emergency transportation for Williamsburg County.

The collaborative team will utilize the Williamsburg Regional Hospital Health Center to provide quality care in alignment with evidence based guidelines. A memorandum of understanding has been established between the collaborative partner – Williamsburg Regional Hospital and Williamsburg Regional Hospital Health Center. Once the participants are contacted and the program is explained, the patient will sign an attestation form stating they have no insurance coverage. After this is complete, a meeting will be arranged with a Medicaid Counselor and a Certified Application Counselor for screening for Medicaid and other Affordable Health Programs. If a potential participant cannot be contacted, a flag will be placed on their electronic medical record, notifying ED registration that the patient may qualify for the program. At that time, case management will be notified and will approach the patient about the program. The Case Manager will be instrumental in coordinating the shift of primary care from the ED to the Health Center.

Once the patient is referred the Health Center, the Family Nurse Practitioner will conduct a Social Determinant Screening and a Behavioral Health Screening in order to devise an individualized care plan, community service referral, and any other necessary referrals. A physician co-coordinator is on staff and available as needed. The patient's medical record will be reviewed and data compiled for reporting once the templates are available from the SCDHHS. The Nursing Directors and Administration will be responsible for data collection and follow up.

The Williamsburg Regional Hospital Health Center is open on Monday, Tuesday and Thursday from 8:30AM – 6:00PM, Wednesday from 8:30AM – 1:00PM and Friday from 8:30M – 4:00PM. Williamsburg Regional Hospital is open 24 hours a day.

Basic assessment equipment is in place at the Health Center. Basic lab work, microbiology, FSBS, and EKGs can be performed there. The hospital can provide more extensive diagnostic testing such as radiology, nuclear med, etc. as needed.

The program will face several health care limitations. There are limited health care resources in Williamsburg County (no OB/GYN, limited primary care providers) to treat patients with chronic illnesses. There are also limitations in social support systems due to strained resources and a high level of poverty. Implementing the plan will require drawing from current resources and adding to the job descriptions of current employees.

Reporting Capacity

The collaborative team will use NextGen EMR to mine and gather data from the acute and ambulatory clinical modules, and from the financial module as needed. The team will also use information input into Meditech Magic software, and may gather data manually as needed. The team will collaborate with HIM, IS, IT, and NextGen consultants to create a flagging system within the EMR to alert the team of a patient's presentation to the ED, and secure patient listings will be provided to registration clerks in the ED so registration can notify the team of the patient's presentation to the ED.

Performance Period

October 1, 2013 through September 30, 2014