SOUTH CAROLINA
Healthy Connections

Healthy Outcomes Plan Update HFMA SC Chapter Spring Payor Summit

March 25, 2016

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Proviso 33.22 Sec A, C, D – Medicaid Accountability and Quality Improvement Initiative

Incentive program to participating communities (hospitals, primary care safety net providers, and community organizations) designed to improve health outcomes and reduce system costs through better coordinated care of the uninsured, chronically ill, high-utilizers, or those who will become high-utilizers of emergency departments and inpatient services

Proviso/HOP Funding

Purpose	Proviso 33.22 FY 16	Proviso 33.21 (Draft) FY 17
2.75% Rate Increase	$31M	$31M
Rural Hospital DSH Payment (100%)	$25M	$25M
301 Alcohol and Drug Abuse Clinics	$2M	$1.6M
Primary Care Safety Net – FQHC	$8M	$6.4M
FQHC – Capital Needs	$4M	N/A
Primary Care Safety Net – Free Clinics	$2M	$1.6M
Primary Care Safety Net – Innovative Care	$6.6M	$4M
Total	**$78.6M**	**$69.6M**

Hospitals

- Non-Rural 10% DSH at Risk for non-participation
- Rural non-receipt of $25,000,000 DSH Allotment Share for non-participation
- Participation through reporting
- Enhancement dollars paid for participants under care plan

Other Providers

- FQHC, Free Clinics, 301 Clinics participate through contracts for specified amounts in Proviso
- Contract deliverables

HOP Monthly Reporting Requirements

- Participants Active Enrolled, Dis-enrolled, and Working to Engage
- Care Plan Status for each active enrollee
- Patient Activation Measure
- Global Appraisal of Individual Needs- Short Screener (GAIN-SS)
- Executive Summary

Participants

As of March 2016:

- 13,914 total enrolled HOP participants
- FY16 Enrollment Target 13,235
- 90% (12,462) of enrollees have complete care plans
- 58% of enrollees screened are in high need of further evaluation or behavioral health intervention

Providers

- 100% participation from 56 SC Medicaid-designated hospitals leading to 44 HOPs

Partnerships

- Estimated 56 Hospitals and 76 Primary Care Safety Net Providers (FQHCs, RHCs, Free Clinics) partnered at 104 sites
- 30 participating behavioral health clinics (MH and DAODAS)

- **Social Determinants of Health**
- **Behavioral Health (BH) Issues**
  - Measured through Global Appraisal of Individual Needs- Short Screener (GAIN-SS)
- **Patient Engagement**
  - Measured through the Patient Activation Measure (PAM)
- **Partnerships**
  - Collaboration within HOPs of Community Organizations, FQHCs, Free Clinics, Hospitals, RHCs, etc.

Successful HOP Must Haves

- Strong administrative and clinical senior leader involvement within all partner organizations (including senior leader champion(s))
- Strong support structure that performs core functions such as enrollment, initial social screening, and walking participants through the health system
- Partnerships within the community that encompass services that are relevant to meeting the needs of participants. Examples: Transportation, Vocational Rehab., Food Pantry, Housing, Social Determinant Organization
- Regular (monthly) partner organization meetings
- Regular discussions among partners regarding fiscal implications associated with operating the plan

- For participants enrolled at least 6 months
- Preventable Inpatient Stays- Lower overall, lower for acute and for chronic preventable inpatient stay rates
- For patients with a care plan, there was a 16% decrease in the overall rate of stays that could have been prevented for chronic conditions
- For patients with a care plan, there was a 7% decrease in the average number of Preventable non-emergent ED visits
- For patients with a care plan, there was a 6% decrease in the average number of emergent ED visits that were primary care treatable
- Preventable Inpatient Stays for patients with a care plan decreased by 16.28%. For patients without a care plan, there was a 1.10% relative increase
- There was nearly an 18% decrease in charges for HOP participants enrolled in the program for at least six months
- Report: **Measuring the Impact of the Healthy Outcomes Plan: Preliminary Evaluation** at: **https://msp.scdhhs.gov/proviso/sites/default/files/hop_evaluationseptember2015_formatted_final_pdf_secured.pdf**

- **Patient Activation Measure (PAM)**
  - Comparison 2014 to 2015
  - Level 3- Taking Action: Increased from 33.46% to 34.42%
  - Level 4- Engaged: Increased from 25.65% to 26.72%

- **Global Appraisal of Individual Needs- Short Screener (GAIN-SS)**
  - Comparison 2014 to 2015
  - Participants in High Need of Increased Behavioral Health Intervention decreased from 60.57% to 58.75%

Stories To Tell

- In February, 2014, AccessHealth Lakelands enrolled a client that had a history of seizures, alcohol use and other health conditions, who frequently came to the ED with seizure activity and was many times admitted to the hospital for this condition. His assigned Community Health Worker (CHW) soon realized that this client had a number of barriers that prevented him from taking care of his health. These barriers included social, educational, and financial needs. Although this client had a PCP, he did not have transportation to go to appointments or money to pay for needed medication. At times, this client did not have access to a phone. Our CHW developed a plan to assist this client. She arranged transportation for MD appointments and made visits to the client's home to remind him of his appointments when she could not reach him by phone. She also connected the client to medication assistance. This CHW continued to work with this client to educate him on the importance of taking care of his health and she rewarded him with items from our Compassionate Care Closet as he met goals. Her work with this client has made a tremendous impact on his health. In 2014, this client had 10 in-patient hospital visits and 6 ED visits. As of September, 2015, this client has had 2 inpatient hospital visits and 1 ED visit. This client's overall health has improved, he is more responsible for caring for himself, and he knows that he has his CHW to help guide him along the way.

- Focus on care management and improving Inpatient and ED metrics across the state
- Focus on Behavioral Health and Patient Engagement strategies
- Community Health Home Concept
- Possible integration of Telehealth

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