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Value-Based Healthcare Through Care Coordination and Clinical Integration

Angelo Sinopoli
Greenville Health System

Jennifer Snow
Greenville Health System

Value-Based Healthcare Through Care Coordination and Clinical Integration

GREENVILLE HEALTH SYSTEM

Angelo Sinopoli, MD
VP, Clinical Integration
Chief Medical Officer

Strategic Positioning

Multi-Year Goals

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Total Health Organization	• Right Care, Right Time, Right Place • Clinical competencies to perform under Health Reform
Health Care Value Leader	• Business systems and structures to perform under Health Reform • Partnerships with payers and industry • Cost efficient, quality focused
Clinical Integration	•Systems, structures, and processes to improve operating performance •Network development for FFS business and for population coverage •Building and linking the healthcare continuum
Innovation in Academics	• Leverage academics to improve clinical and financial performance • Create a clinical workforce to lead in a reformed healthcare environment
Sustainable Financial Model	• Efficiently create and allocate resources to achieve mission • Strong performance in today's environment while positioning for Health Reform

“Population Based Care”

The new mantra of healthcare.

Beyond the Medical Home

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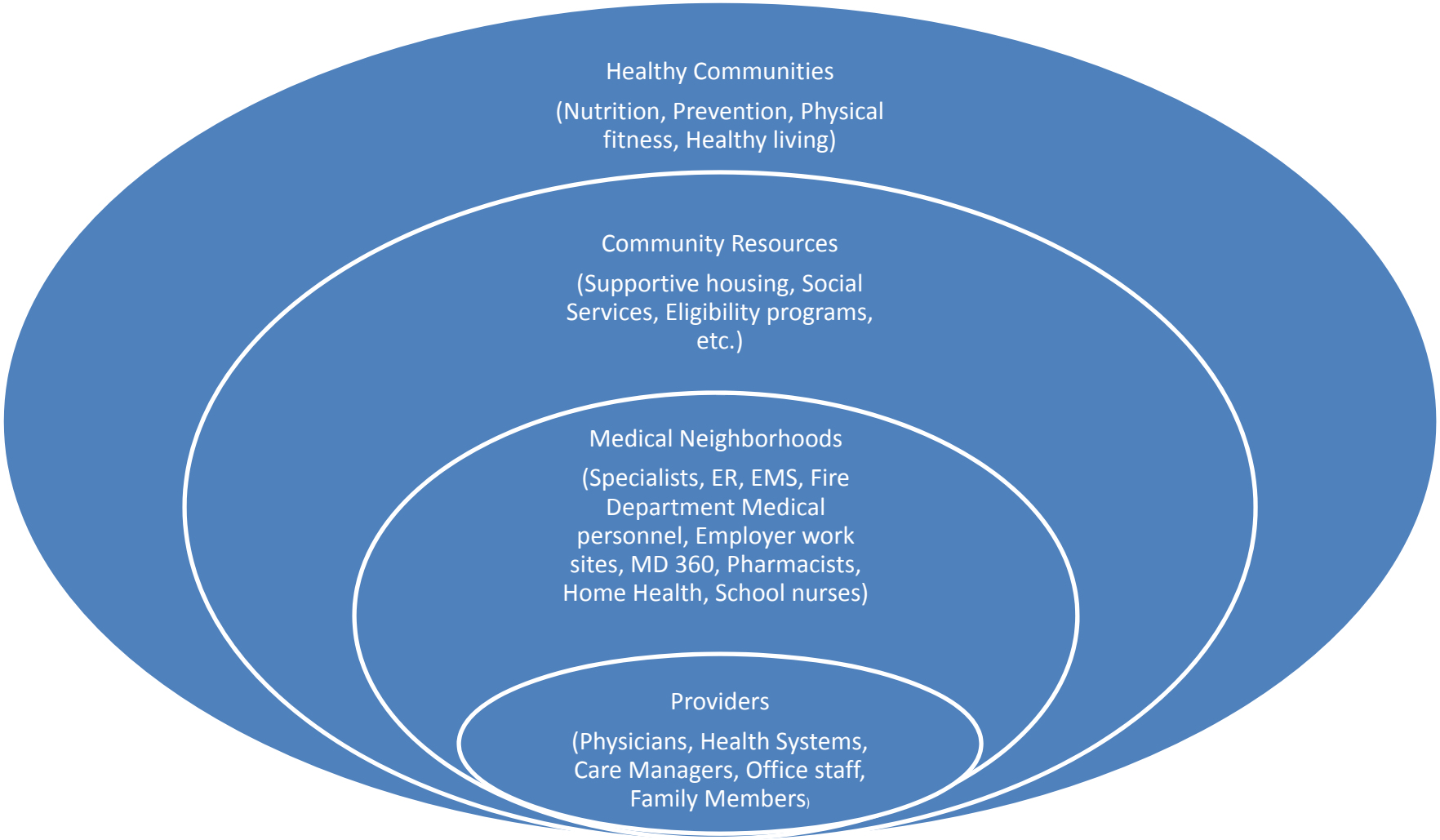

Strategic Positioning
Accountable Care Organization
The Care Continuum

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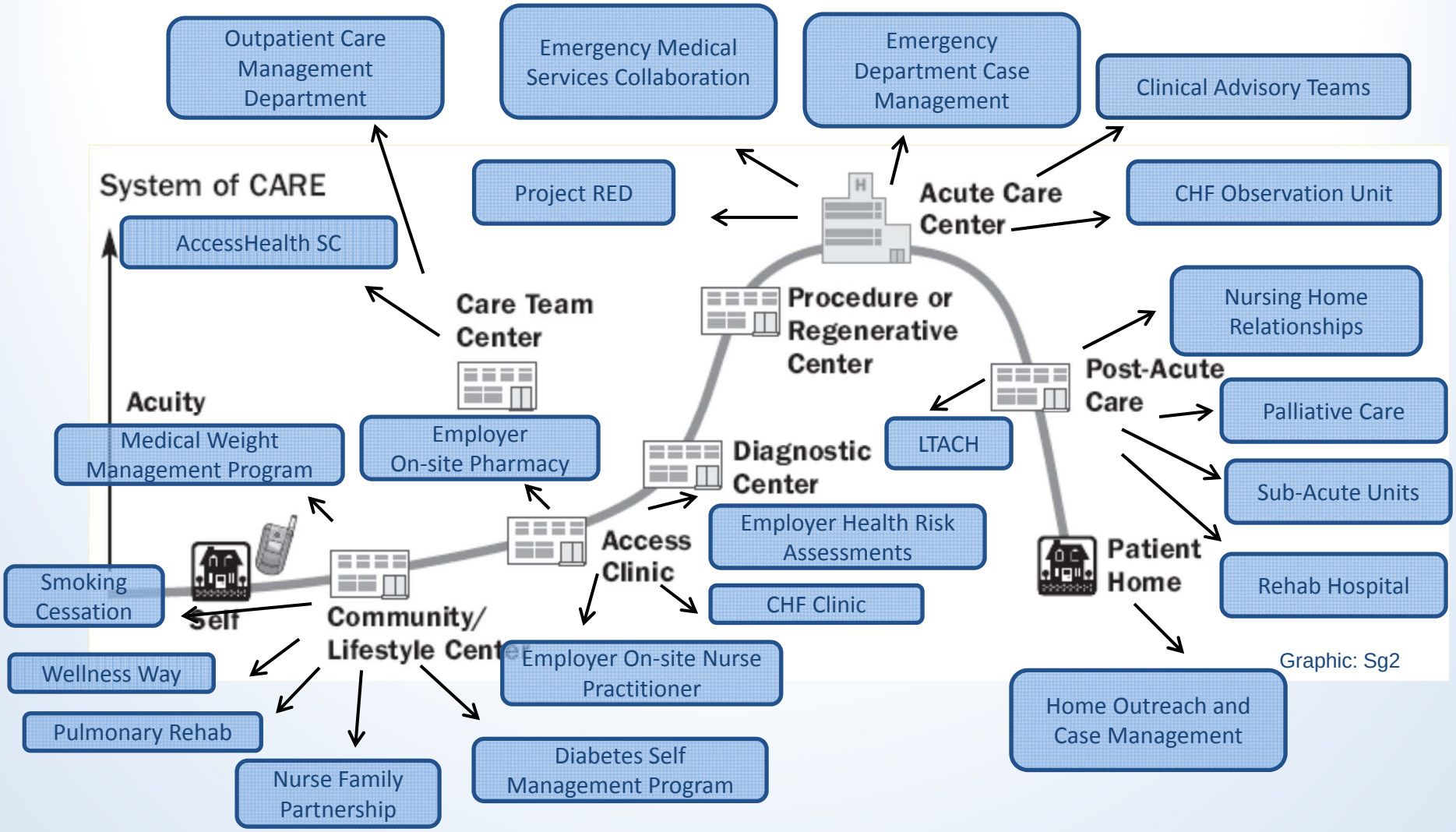

Information Systems

Care Coordination Competencies

Duke Innovation Grant

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Overview:

- $2.7 million grant for delivery innovation

Eligibility:

- Initial pilot focused on Medicaid clinic population and subsequently the unfunded population
- Developed a stratification process based on ER and hospital utilization

Duke Innovation Grant

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Areas of Focus	Process and Infrastructure Changes
Access	Added a NP to improve access
Care Management and Coordination	Added nursing case management and social work to provide care management and coordination Connected to ED case management program
Self-Management	Developed diabetes and pulmonary self-management programs
Clinical Decision Support System	Developed and implemented quality outcome monitoring methods using PQRS within the electronic medical record
Education	Educated physicians, staff and patients as to the processes and intent of the program
Data Reporting	Developed monthly outcome reporting tools for feedback to physicians and leadership

Duke Innovation Grant

GREENVILLE HEALTH SYSTEM

Results to-Date:

- In year one, there was a **26% decrease** in Emergency Department visits and a **55% decrease** in inpatient days
- For Diabetes, the number of patients with HgA1c High values (>9%) **decreased 14%**
- LDL-C Abnormal values **decreased 15%**
- For Hypertension, Non-Diabetic, the number of patients with readings within 140/80 parameters **improved approximately 13%**
- For Asthmatics, the number of patients appropriately receiving corticosteroid/acceptable alternative therapy **improved approximately 11%**

ER Care Management

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- 130 Patients Enrolled
- Active Case Management
- Connecting to a Medical Home
- Addressing Social Issues

GHS/EMS Partnership

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Awarded a $300,000 grant to reduce unnecessary ER and EMS utilization by:

- Creating an innovative nurse triage call center that is currently being used in only two other locations in the US
- Providing care coordination to ER and EMS high utilizers so they receive the right care at the right time and place
- Developing patient-centered medical neighborhoods within the community

South Carolina FOUNDATION

Community Care Outreach

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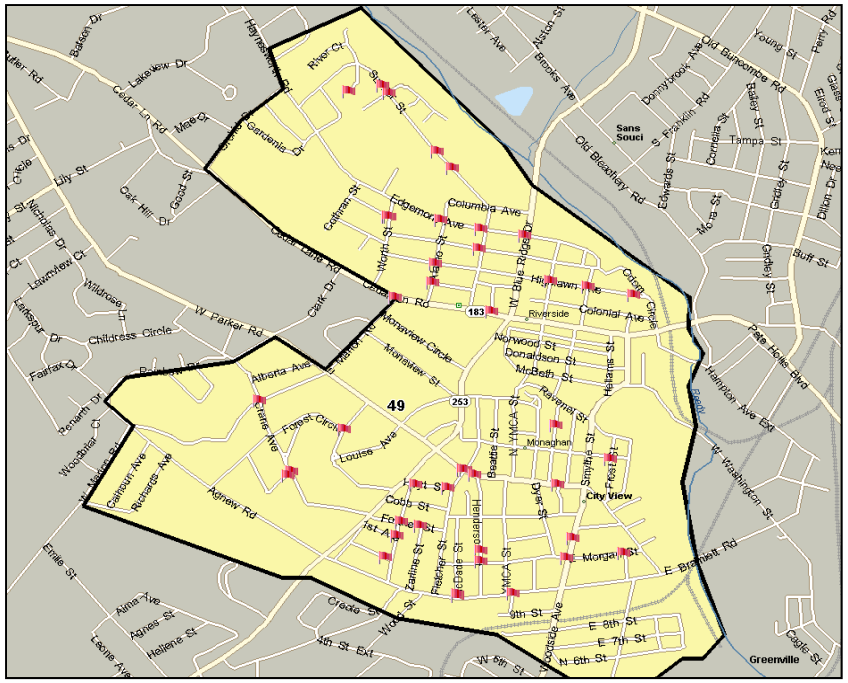
Collaboration between GHS, GCEMS, and Greenville City Fire Department to create patient-centered medical neighborhoods within the Greenville Community.



Medical Neighborhoods

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- Health System and Safety-net Collaboration
- Providing Access to Care within Communities
- Community Paramedic and Health Worker Models
- Home Health
- Mobile Health Clinic
- Care Management
- Care Coordination

Patient-Centered Medical Neighborhoods Initiative

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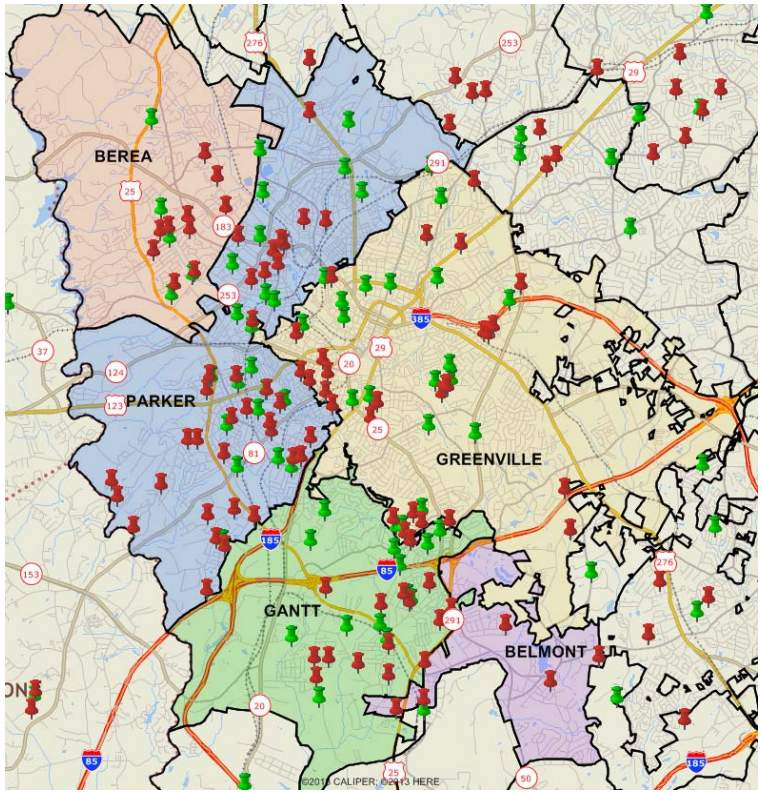
- BCBSSC Grant Year Three
- Proviso 33.34
- ED/EMS High Utilizers
- Pilot Neighborhoods:
  - Parker
  - Berea
  - Gantt
  - Belmont
  - Dunean Mills



Accountable Communities

- Community-led Innovation
  - Community Volunteer Programs
  - Community Paramedics
  - Community Resources (Faith-Based Organizations, Schools, EMS, Police and Fire Districts)
- Patient Education and Social Determinants
- Population Health Management
- Social Service Providers

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CARE
COORDINATION
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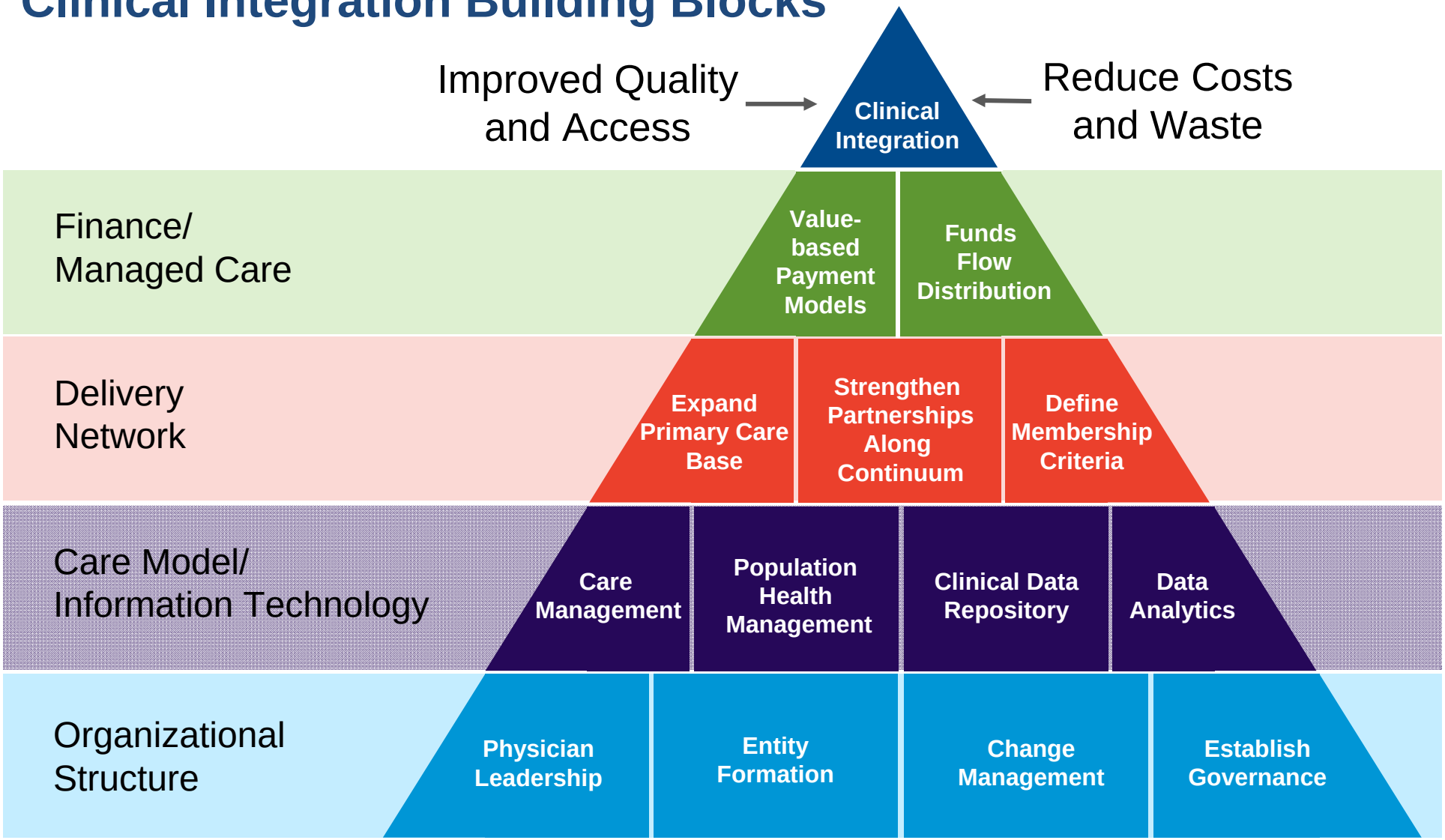
Clinical Integration Building Blocks



CARE COORDINATION INSTITUTE

Research & Publications

- CER
- Support CCI
- Publications
- Grants and Contracts

Quality Improvement

- Education
- Data Driven Change Management
- Predictive Analytics
- Best Practice Development and Research
- Industrial Engineering and Process Improvement

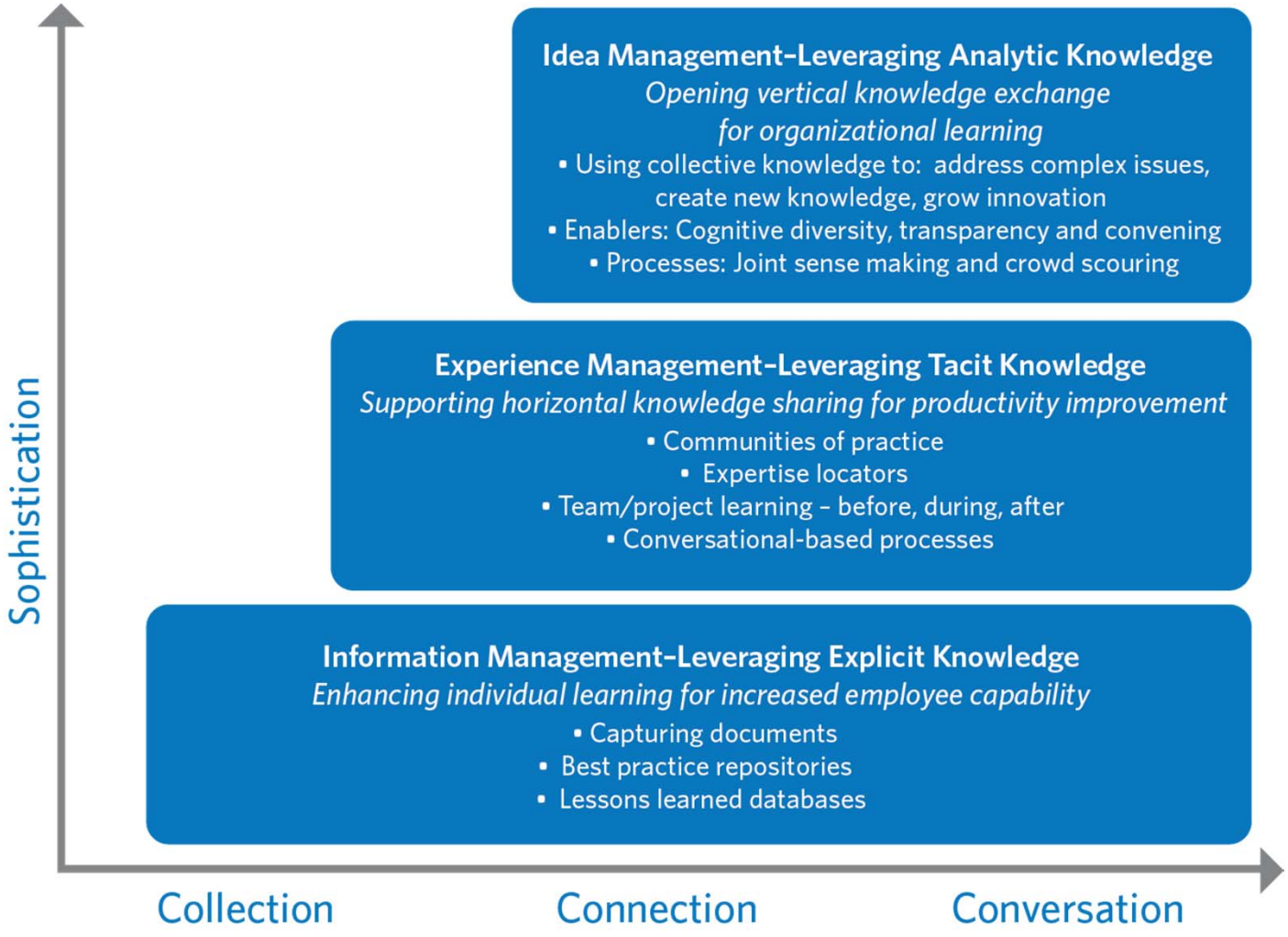
Care Coordination

- Education and Training
- Tool Kit Development and Resources
- Care Management Technology Tools
- PCMH
- Patient Engagement/Patient Experience
- Transitions of Care
- Hospice, Palliative Care

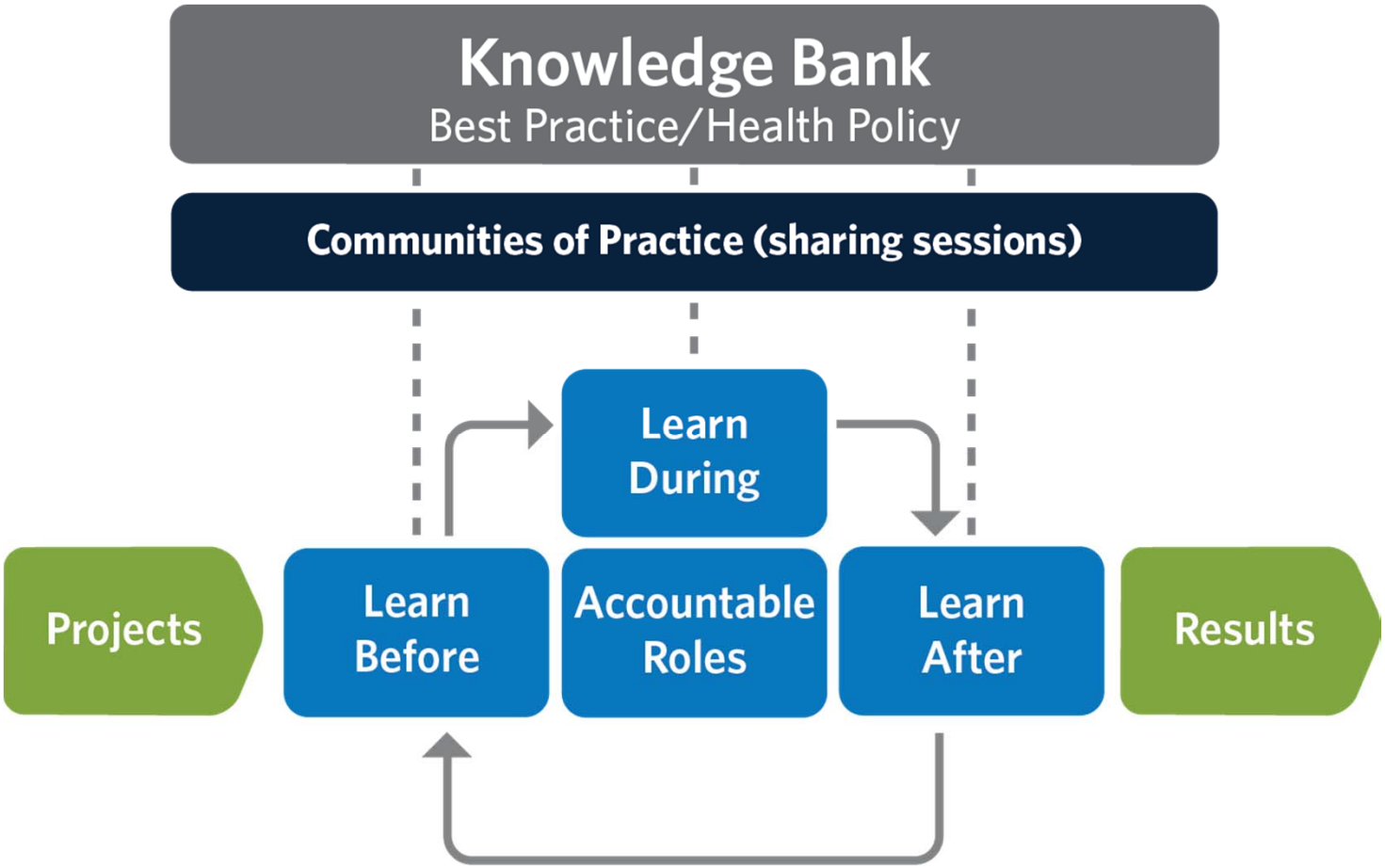
Health Informatics

- Data Analytics
- Provider Scorecards
- Benchmarking
- HIE

Evolution of Knowledge Management



Learning Cycle



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