South Carolina FOUNDATION

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Grant Application

Contact Information

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Project Summary

Project Title: Community Care Outreach Project
Grant Request Amount: 300,000 over 3 years
Grant Period (mm/yy – mm/yy): 6/2012 – 5/2015

Organizational Background

Provide a **brief** history of your organization, including the date of inception and significant growth.

Greenville County EMS (GCEMS) and Greenville Hospital System (GHS) are partners in this program, with GCEMS serving as fiscal agent.

GCEMS was formed when Greenville County Council authorized the acquisition of federal monies and provided the matching funds to form an Emergency Medical Services (EMS) department in Greenville County. On April 1, 1975 the EMS System began operations. Beginning with six ambulances under the direction of several private providers, the System ran 7,098 calls in its first year of operation. Since that time the annual volume has grown to over 54,600 response runs per year and over 157,000 phone calls.

GHS looks very different today as compared to its beginnings in 1912 as Greenville City Hospital — the first public hospital and "training school for nurses" in Greenville. Over the years, GHS has progressed from a standalone hospital serving the city of Greenville, to a hospital serving a county (1947 - Act 432), to the nation's first hospital system with a satellite hospital serving a major urban hospital (1952 – Allen Bennett), to an integrated delivery system with academic teaching and research programs (1983 – elective rotations for University of South Carolina students) serving the 10-county Upstate. This truly unique organizational evolution was necessary for GHS to continue to serve its mission in a rapidly changing healthcare market place.

List your organization's mission and vision. How does your mission guide where or how you work? Also include any principles or values that you actively use. (Please keep brief, 1-2 paragraphs.)

GCEMS: Our mission, as compassionate professionals, is to provide exceptional pre-hospital care in a timely and efficient manner to the citizens and visitors of Greenville County. GCEMS is dedicated to providing excellent pre-hospital care based upon evidence-based treatments; data drives our decisions in establishing clinical excellence. We do this through data collection and analysis, patient care report reviews, quality Improvement meetings and protocol review and assessment. In addition, we guide our actions and operations according to STAR CARE (Safe, Team-Based, Attentive to Human Needs, Respectful, Customer Accountable, Appropriate, Reasonable, and Ethical. Our standards have been developed according to widely accepted treatment practices at local, state, and national levels. These standards have been reviewed and endorsed by Martin Lutz M.D., Medical Director, and John R. Zaragoza, Director, Greenville County EMS.

GHS: Mission: Heal compassionately. Teach innovatively. Improve constantly. Vision: Transform health care for the benefit of the people and communities we serve. Values: compassion, respect, caring, honesty, integrity, and trust, exhibited daily through communication, forward thinking, creativity, continually striving to improve, responsiveness, a willingness to change, education, research, and clinical quality. The structure and configuration of GHS reflects its mission, the environment in which it operates, and the strategic choices made by leadership over the years. GHS is a not-for-profit academic health organization committed to medical excellence through research and education and is accredited by the Joint Commission of Accreditation of Hospital Organizations (JCAHO). Our five campuses provide integrated healthcare to communities across Greenville County and beyond through a tertiary referral and education center, community hospitals, a long-term acute care hospital, nursing home, outpatient facilities and wellness centers. GHS is the safety net hospital for Upstate South Carolina and is a governmental entity public hospital without tax support. It is a horizontally and vertically integrated delivery system which is the only provider in South Carolina

capable of becoming an ACO, according to SC Department of Health and Human Services Director Anthony Keck. By any measure, GHS and its medical staff provide excellent care to those who are seen in our physician practices and hospital facilities, but cannot completely address the underlying causes of disease and health by merely working harder in its current care delivery model. GHS must continue to evolve and transform in a manner that further integrates teaching, research, and clinical service within a structure that enhances not only how the diagnosis and treatment of injury and illness, but allows a focus on preventing their onset.

Please provide a **brief** description of the programs or services you provide.

Greenville County EMS (GCEMS) is the sole 911/ALS provider of emergency services for Greenville County, the most populous county in South Carolina, with geographic area of almost 800 square miles of varying terrain from mountains to rural pasturelands. A dynamic high performance EMS system, GCEMS deploys up to nineteen ambulances and six Quick Response Vehicles (QRV) 24/7. Most of these ambulances are centrally deployed, while six ambulances and two QRVs are deployed from various strategic geographic locations within the county. Of the 221 field providers, 166 are certified as paramedics, 46 are certified as EMT-Intermediate and 9 as EMT-Basic. In calendar year 2011, GCEMS responded to 54,647 calls with a 90th percentile response time of 12:13 minutes for the most critical and life-threatening (Delta and Echo) calls.

GCEMS also operates an accredited EMS specific Priority Medical Dispatch high performance Communications Center staffed with EMD certified personnel. Communications staff use strict medical priority dispatch algorithms to determine specific details of incidents, provide "pre-arrival" medical care instructions to the caller and dispatch appropriate medical resources. Considered a secondary PSAP, this center is responsible for all communication activities for thirteen Fire Departments, the County Coroner's Office and GCEMS.

Greenville Hospital System (GHS) is the safety net hospital for Upstate South Carolina and is a governmental entity public hospital without tax support. It is the largest hospital system in South Carolina, with 5 campuses, 9 hospitals, 1268 beds, 42,570 admissions, 37,000 surgical procedures, and 1.8 million outpatient visits in 2010. GHS has a Level I trauma center and Level III nursery. There are 10,000 employees including 600 employed physicians, 350 of whom are experienced clinical teaching faculty of USCSOM-Greenville. GHS is also a clinical university providing clinical education for more than 5000 students per year from health profession programs of affiliated education institutions. It remains committed to physician integration and physician leadership.

Briefly describe your core expertise. What does your organization do especially well? Be as specific as possible, and focus on ways in which you truly stand out for your expertise.

GCEMS is the key provider of emergency transport and EMS services in Greenville County. In calendar year 2011, the GCEMS Communications Center processed 62,480 responses to 54,647 emergency medical calls, 7,955 fire dispatches, 691 Coroner's calls. In processing those calls, the GCEMS Communications Center handled over 157,000 telephone calls. GCEMS' experience in working with underserved populations who may see no other option for health care other than EMS and the ED make the organization a strong partner for piloting innovative programs offering health care alternatives.

GHS is a key provider of medical services, including those provided in an Emergency Dept. (ED) setting. The organization is committed to education of health care professionals, the transformation of health care and is constantly striving to improve. As part of these commitments, GHS is a leader in

seeking innovative ways to provide first-rate health care in the most efficient, cost-effective manner. An example of the expertise GHS has nurtured is found in its research and program initiatives. HEALTH SERVICES research has been organized into an entity called IAHC (Institute for Advancement of Health Care). It will be the link for USC and GHS collaborative research involving care delivery innovation, individual and population based outcomes, comparative effectiveness, implementation science, and heath care policy. Successful pilot projects have been completed for medically underserved patients involving: (1) extended hours pediatric access to reduce ED utilization; (2) focused ambulatory care management to reduce episodes of crisis in pediatric asthma; (3) care partners to improve prenatal care and reduce premature deliveries in primiparous single women; and (4) targeted ambulatory care coordinators to improve chronic disease treatment markers, decrease ED utilization, and reduce inpatient days.

GHS TOTAL HEALTH INITIATIVES: Medical education recognizes the urgency for physicians to integrate public health strategies in order to mitigate chronic disease, reduce health disparities, and reduce health care costs (Maeshiro, Koo and Keck, 2011). "As suggested by the CDC Experience Applied Epidemiology Fellowship, we need physicians with a "population health perspective." (http://www.cdc.gov/cdcexperiencefellowship/). GHS embraces a population health perspective via its "Total Health" philosophy; the IAHC is our infrastructure facilitating evaluation of intervention impact.

A few distinctive features of this model include: (1) concern for cost as well as clinical effectiveness, (2) emphasis on care for chronic disease and prevention, (3) understanding psycho- social contributions to health management, (4) viewing individual behaviors within contexts that contribute to disease or enhance health, (5) realization that some individual or environmental conditions exert disproportionate influence on health, so one can leverage these factors to achieve maximal impact in preventing adverse outcomes and promoting optimal health.

Training the workforce using this model may change health outcomes. For example, the clinician practicing in accordance with the model appreciates the importance of promoting healthy eating and physical activity for reducing risk of diabetes. Integrating education in those areas more fully into medical education increases the likelihood of incorporating health educators, dieticians, exercise scientists, pharmacists, and social workers into the patients' care team, and of forming alliances with community groups and businesses, including grocery stores, to enhance healthy food choices. Finally, the role of the patient within the context of the patient's life becomes a valuable asset and the outcomes to be measured take patient values, life stage, and environment into account.

Current Total Health Initiatives are 1) *AccessHealth:* A Duke Endowment grant supported project developing a community network of care for Greenville County's low-income, uninsured population. AccessHealth supports the community in creating and sustaining coordinated, data-directed provider networks of care establishing medical homes and ensuring timely, affordable, high quality healthcare services for low income uninsured people in South Carolina and North Carolina. 2) *The Total Health Pilot Program:* A project to redesign health care delivery for a group of particularly high-risk Medicaid and charity care patients meeting specified disease and healthcare utilization criteria. Preliminary analyses suggest the program favorably impacts diabetic and hypertensive patients via the program's Total Health care management model, and consequently decreases utilization of acute care and impatient resources.

Both Access Health and the Total Health Pilot Program are key examples of GHS' strength in and commitment to integrated public health strategies designed to work with the barriers and other issues faced by medically under-served patients.

What has your organization achieved in the past three years for the population this grant request is targeting?

Both GHS and GCEMS are cognizant of the fact that Medicaid and charity clinic populations with high risk diagnoses are often high users of the EMS transport system and the ED. We have implemented the **Duke Innovation Grant – a** $2.7 million grant for delivery innovation piloted to focus on this population. Through the program we have:

- Developed a stratification process based on ED and hospital utilization
- Access - added a NP to improve access
- Care management and coordination:
  - Added nursing care management and social work to provide care management and coordination
  - Connected to ED care 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
- Results to-Date:
  - In year one, Medicaid patients had a 26% decrease in Emergency Department visits and a 55% decrease in inpatient days; charity patients had a decrease of 14% in inpatient days and 31% in ED visits
  - In year two, Medicaid patients admitted in year one had an **additional** decrease of 16% in inpatient days and 8% in ED visits; Medicaid patients admitted in year two had a 14% decrease in inpatient days and 31% in ED visits; in the first six months, charity patients have had a 56% 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%
  - Currently in year 3, there are 200 patients enrolled in program

List your organization's primary supporters/funding sources? Estimate the percentage of support from the various sources.

Primary Supporter/Funding Source	% of Overall Funding
GCEMS -billing	100%
GHS – Net Patient Services Revenue	97.62
GHS – other revenue and contributions	2.38

What do you rely on to sustain your organization? Please speak to financial and program factors?

GCEMS and GHS both rely on patient billing for sustainability; however GHS also pursues private,

foundation and corporate funding for special projects such as this one.

Project Information

Project Title

Community Care Outreach Project

Purpose of Grant (one sentence)

Funds will be used to implement a two-phase project to reduce both unnecessary patient use of EMS transport to area ED's and unnecessary patient use of ED's, while providing quality medical care to frequent EMS/ED patients living in designated underserved areas.

Grant Request Amount	Total Project Costs	Grant Period (mm/yy – mm/yy)
$300,000 over three years	$2,165,000 (over three years)	6/2012 – 5/2015

Is this a new project for your organization? (Y/N) If No, how long has this project been in existence?

Yes, this is a new project.

Project Details

1. What problem is the project addressing? We are aware of the seriousness of most issues, so limit this to a few sentences.

Inappropriate calls to emergency medical service (EMS) providers and unnecessary use of the emergency department (ED) occur frequently, with a handful of "frequent fliers" accounting for a disproportionate share of the problem. These individuals generally lack health insurance and a medical home and face multiple barriers to accessing care, causing them to repeatedly turn to EMS providers and local EDs with problems that could have been prevented and/or do not require immediate care by EMS or ED staff. The net result is higher costs and the diversion of valuable resources away from true emergencies.

The key issues to be addressed will be:

1) The high EMS/ED utilization, dominated by a few (often uninsured) users;
2) Often for non-urgent needs or those the ED is not equipped to handle: Various studies have found that between 11 and 52 percent of 911 calls come from individuals who do not face serious health problems. In addition, many ED visits by frequent fliers are for conditions that should be treated in a primary care setting. Frequent fliers also routinely call 911 and visit the ED with exacerbations of chronic conditions that could be avoided with adequate ongoing care and for psychosocial problems that cannot be effectively treated in the ED, such as alcohol or drug dependency and depression.
3) Leading to high costs, diverted resources, little lasting value for callers: Handling nonemergency calls raises the costs of providing EMS and ED services and diverts scarce resources away from true emergencies, leading to longer response times. In addition, although those who respond to these cases can resolve the immediate problem(s) at hand, they lack the resources and

knowledge to educate the individual about appropriate self-management and the many community-based resources (e.g., home health care, behavioral health services, public health clinics, substance abuse services) that could better address their needs in the future.

2. What is the geographic service area, including the counties?

Greenville County

3. Approximately how many individuals in the service area are affected by the specific problem?

Residents of Greenville County – 450,000 people

4. Who is your target population? Will your project focus on a subset of the entire population with the problem? If yes, explain the characteristics of your target population. How many people do you plan on serving?

This project will initially impact a targeted group of patients who use EMS transport for non-emergency medical needs. This population is considered vulnerable due to being uninsured and having other barriers to health care such as poverty, lack of transportation, etc. The second phase of the project will reach a broader group that also includes those who use the ED for primary and non-emergency medical care, regardless of transport method.

The total estimate of the number of people who will be served each year is 500.

5. Considering your population, tell us about what difficulties you anticipate in reaching the desired outcome/result. Specifically, what barriers do you anticipate?

In previous years the acceptance of federal funds and the designation as an EMS System has meant that no patient could be refused treatment and transport because of the inability to pay. However, due to an overwhelming number of non-emergency calls, GCEMS has received special designation from DHEC to not transport in non-emergency cases. The barriers we anticipate in discouraging frequent non-emergency use of the EMS/ED include lack of transport for patients to appropriate medical facilities (primary care physicians, clinics or urgent care offices) and changing the overall patient psychological mindset of using the ED as a primary care center.

6. What is the proposed project? In summary form, please tell us what you will do.

Funds will be used to implement a two-phase project to reduce both unnecessary patient use of EMS transport to area ED's and unnecessary patient use of ED's, while providing quality medical care to frequent EMS/ED patients living in designated underserved areas. This project will be implemented in two phases, with the initial phase beginning in July 2012. Analysis of current EMS transport to area ED's indicates that 65% of the 911 ambulance calls are for non-emergency care, yet EMS is required by law to transport patients unless a waiver is signed declining transport. This project will use a new triage and follow up method at the time of the call, before an ambulance is dispatched, to encourage alternate care. Phase two will add pre-emptive at-home or in-community care for patients who use the ED inappropriately and/or frequently.

Phase one: A software program will be purchased and installed at the EMS dispatch center that will allow dispatchers to enter caller information to ascertain the level of emergency. Those that are non-emergency and should not require EMS transport will be routed to a newly created on-call nurse bank. The nurse will speak with the caller and encourage an alternate form of medical care, whether it be

advice over the phone or scheduling of an appropriate method of non-emergency care.

Phase two: Anticipating that phase one will reduce the level of non-emergency EMS transports, EMS paramedics and/or nurses will staff a mobile medical unit (most likely an ambulance) that will visit patients who have been identified as those who over utilize the ED. Research shows that primary causes of unnecessary ED and EMS use are lack of transportation, lack of a primary care physician, and lack of funds. In cases where a nurse/paramedic intervention could resolve a medical issue, home or community access to care should result in a significant decrease in EMS and ED costs. Additional benefits will include reduced ED congestion, lower community costs from un-reimbursed emergency charity care, and a healthier community due to better medical management of non-emergency health issues.

This project has the potential to have both significant cost savings in terms of un-reimbursed care and Medicaid costs, as well as ripple cost savings effects from better management of non-emergency medical issues and chronic disease.

7. Do you have evidence that this is the best approach? If so, briefly explain.

Similar projects have been piloted in Texas with positive results. The Area Metropolitan Ambulance Authority (more commonly known as MedStar), an emergency medical service provider serving the Fort Worth, Texas area, uses advance practice paramedics to provide in-home and telephone-based support to patients who frequently call 911. Working as part of MedStar's *Community Health Program*, these paramedics conduct an in-depth medical assessment, develop a customized care plan based on that assessment, and periodically visit and/or telephone the patient and family to support them in following the plan. Support generally continues until they can manage on their own. A separate, similar program serves individuals with congestive heart failure, and the same concept is being tested with hospice patients and may later be expanded to serve those with other chronic conditions. The program significantly reduced 911 calls, leading to declines in emergency medical service and emergency department charges and costs, and to freed-up capacity in area emergency departments.

MedStar ambulance service in Forth Worth, TX has shown the following results with their program:
1) Significantly reduced 911 calls, leading to declines in EMS and ED charges and costs, and to freed-up capacity in area EDs.
2) Significant decline in 911 calls: Between the formal launch in July 2009 and August 2011, the volume of 911 calls from the program's 186 enrollees fell by 58 percent, from an average of 342.3 monthly calls during the 6-month period before enrollment to 143.3 monthly calls afterward.
3) Corresponding declines in EMS and ED charges and costs: The decline in calls has led to a corresponding drop in MedStar's charges and costs, with annualized EMS transport costs for these patients falling by over $900,000 (from $1,577,472 to $660,128) and charges falling by over $2.8 million ($4,929,600 to $2,062,899). Based on information provided by area EDs, MedStar estimates similarly large declines in ED charges and costs for patients transported by MedStar to area EDs, with charges falling by nearly $9 million and costs by over $1 million. (The large difference between charges and costs stems from the many uninsured patients being served and the low rate of reimbursement by public payers, particularly Medicaid. Consequently, full charges are set at a level that allows adequate collections to cover costs.)
4) Freed-up ED capacity: MedStar estimates that the decline in patients being transported by ambulance has freed-up more than 14,000 bed hours at area EDs, allowing these capacity-constrained facilities to better serve those facing real emergencies.

8. Please summarize major activities and target dates.

Program activities and target dates:
Phase 1 (Year 1)
Hire program manager/nurses – summer 2012
Establish Call Center/Implement Software – summer 2012

Phase 2 (Years 2 and 3)
Establish Care Coordination program for qualifying patients - summer 2012
On-going evaluation of benchmarks and outcomes

Results

9. What specific outcome/result will the project achieve? List the specific outcome measures that define success. How many individuals will achieve the results that define success?

Phase 1/Year 1:
Get the program up and operational by hiring staff and creating the call center with the software. Begin using the triage center to coordinate patient care to the appropriate providers within the community instead of the ED.

Phase 2/Years 2 and 3:
Patient-centered medical neighborhoods will be established based upon geographic distribution of non-emergent EMS calls. Patient care will be coordinated by partnership among EMS, GHS, Free Clinics, New Horizons and others providers as needed.

Year 2:
Reduced # unnecessary visits to ED via EMS transports to GHS by 5%

Year 3:
Reduced # unnecessary visits to ED via EMS transports to GHS by 10%

Increased # visits generated by advanced paramedic protocol (visits made by paramedics in preventive medical program)

10. How will you know your results have been achieved?

Results will be measured by comparing initial goals to specified benchmarked outcomes. We will gather data from the EMS software triage system, ED and EMS statistics, increased use of New Horizons, Free Clinic etc. as medical homes (referrals will be tracked in the software triage system)

11. In a few sentences, describe how long and the required level / intensity of the intervention are needed in order to achieve the desired results.

This two phase project will be implemented over 3 years – Years 1 and 2 will implement the 2 main areas of the project: Year 1 – software and call center implementation, Year 2: patient centered medical neighborhood programs established, Year 3 – coordination of both elements of project to test overall effectiveness. After the initial three years, we hope the desired results will be achieved and long-term behavioral changes will manifest in the patient population as related to EMS, ED's and

preventive and non-emergent care via a medical home.

12. What additional benefits could be achieved from the project's success and should be considered as part of the return on investment?

Behavioral changes over the long term will be part of the return on investment as people take charge of their own health and utilize appropriate levels of care throughout the system.

Tracking Success

13. How will the organization know when your results have been achieved? What information will be used to verify success?

We will verify results via EMS calls/transports, triage calls, EMS preventive calls and other health care statistics as available.

Key People and Groups

14. Who is the person who will lead the project to its results? What characteristics in that leader most predict success?

Angelo Sinopoli, M.D., is the project leader. He is currently Vice President for Clinical Integration and Chief Medical Officer at GHS. He joined Greenville Hospital Sy,stem University Medical Center (GHS) first in 1982 as a resident and then, after completing residency as a member of the Pulmonary Critical Care faculty in 1987. Dr. Sinopoli is responsible for leading the development and implementation of health care delivery initiatives involving clinical integration with particular emphasis on outcomes to include quality, access, efficiency and related physician alignment necessary for GHS to function as a highly integrated delivery system and accountable care organization. This role includes leadership regarding care coordination/management as well as development of programs for population health and business health initiatives.

15. Who are the key persons who will deliver the service? What factors most suggest that they can help people to get to the intended results?

The key persons who will deliver the service are the EMS paramedics, triage nurses at the call center, Dr. Sinopoli (project leader), and social workers and care managers at the ED.

16. Are there any partners critical to this project's success? If so, please list them and indicate both what role they must play and the evidence that they are committed to that role.

This project is a partnership between GCEMS and GHS. Each plays a critical role in the success of this project.

Financial Requirements

Complete the budget form, in excel format, and submit with the application.

17. Provide a brief summary of key expenses.

Summary Breakdown of Use of Funds:

Phase 1:	5 FT nurses @ $70,000 each/ yr to staff call center
	Triage Software (1 time purchase) @ $65,000
	Software Interface @ (1 time purchase) $30,000
	Project Director @ $90,000/yr
	Medical Director (PT) @ $20,000/yr
	Office expenses and telecom costs @ $50,000/yr
Phase 2:	3 FT EMS paramedics @ $40,000 each/yr
	Ambulance operation costs @ $100,000/yr
	Ambulance repair, maintenance etc. @ $50,000/yr

*The requested $300,000 will be split equally between GCEMS and GHS each year to cover operational and staffing costs.

18. If the project serves more than one county, indicate distribution of funds per county.

This project will serve Greenville County.

19. Briefly describe your strategy to sustain the proposed project.

Additional funding for this project will be obtained through in-kind donations from GHS and EMS, Medicaid reimbursements and cost savings sharing, and other foundation and corporate support as available.

Attachments

1. Completed project budget, in Excel format
2. Copy of current IRS determination letter indicating 501 (c)(3) tax-exempt status
3. Copy of IRS Form 990
4. List of Board of Directors and officers, with affiliations, addresses and telephone numbers
5. Organizational operating budget
6. Copy of most recent audited financial statement

Project Budget
Multi-Year Grant

Organization: Greenville County EMS
Project Title: Community Care Outreach Project

South Carolina FOUNDATION

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Sources of Revenue	Year 1	Year 2	Year 3	Total
Reqested from BCBSSC Foundation	100000	100000	100000	$ 300,000
In Kind from GCEMS and GHS				$ -
				$ -
				$ -
Total Revenues	$ 100,000	$ 100,000	$ 100,000	$ 300,000

Program Expenses	Year 1	Year 2	Year 3	Total
5 FT nurses @ $70,000 each	350000	350000	350000	$ 1,050,000
Triage Software	95000	0	0	$ 95,000
Project Director (FT)	90000	90000	90000	$ 270,000
Medical Director (PT)	20000	20000	20000	$ 60,000
Office Expenses/Telecom	50000	50000	50000	$ 150,000
3 FT EMS Paramedics @ $40,000 each	0	120000	120000	$ 240,000
Ambulance Operation Costs	0	100000	100000	$ 200,000
Ambulance repair, maintenance etc.	0	50000	50000	$ 100,000
Total Expenses	$ 605,000	$ 780,000	$ 780,000	$ 2,165,000