Application for LIP Project
Alachua County Health Department
Patient Centered Medical Home Demonstration Project

1. **Applicant**: Alachua County Health Department (ACHD)

2. **Medicaid Provider Number**: 027911100

3. **Provider Type:** County Health Department

4. **Amount applying for:** $755,855

5. **Identify as a new or enhanced program**: Enhanced

6. **Description of the delivery system and affiliations with other health care service providers**

ACHD offers clinical care in two locations, one in East Gainesville and one in the city of Alachua. The main location in Gainesville is located in the area of the county that has a disproportionate number of residents who are socio-economically disadvantaged and medically high risk. The main clinic is a stop on two bus routes which facilitates access to care for those without a vehicle.

ACHD provides face to face medical services at both locations from 7:30 AM to 5:00 PM. Medical care is provided by physicians and nurse practitioners who exercise independent judgment in provision of services. The main facility has 14 exam rooms and the Alachua Clinic has 6 exam rooms. The clinic accepts Medicaid, Medicare, Blue Cross Blue Shield and self pay patients. The self pay patients are seen on a sliding scale, with those under 100% of the Federal Poverty Level (FPL) being seen without payment.

The ACHD provides primary and preventive services, which includes basic labs and radiology, and helps patients access pharmaceutical needs through education on free and reduced cost options, use of pharmacy assistance programs and referral to the county's medication assistance program.

The applicant has a LIP-funded program designed to reduce avoidable use of hospital services. This program includes: case management of individuals who have used hospital services for ambulatory sensitive conditions and are at risk for using them again due to medical problems and socio-economic challenges; on-site Medicaid eligibility determination; and diabetes disease management. The existing diabetes management program will be incorporated into the proposed pilot. The current LIP program has been implemented in collaboration with Shands Hospital and has resulted in improved access to health care, as well as improved health status. In addition to the health benefits resulting from the program, an evaluation of the financial benefits estimates the program has saved the hospital over 3 million dollars.

The ACHD has affiliations with other health care providers though various arrangements. The ACHD co-sponsors the We Care program, which is a collaborative program offered by the applicant, the Alachua County Medical Society and community medical providers, including laboratories and hospitals. We Care also includes a dental program offered in conjunction with the University of Florida College of Dentistry and Santa Fe Community College dental assistant training program. We Care offers medical and dental care to low income uninsured residents who need specialty services without charge.

In collaboration with the UF College of Medicine and other community partners, the ACHD offers care to low income uninsured and Medicaid clients on a mobile unit. Primary care, women's health and testing for sexually transmitted diseases are offered in a mobile outreach clinic in areas where individuals living in poverty are concentrated. The HIV/AIDS program has contracts with local providers for care offered to the HIV positive patients served by the program.

The ACHD is the administrative home of the Oral Health Coalition of Alachua County, which includes all the “safety net” oral health providers in the county, as well as the Alachua County Dental Society. The ACHD works with health care providers through informal referrals, service on advisory committees and other community initiatives. Other safety net providers with whom the ACHD works collaboratively include: ACORN, Helping Hands Clinic, Equal Access Clinic, RHAMA Mercy Clinic and Gainesville Community Ministries.

7. **Service Area:** Alachua County

8. **Service Area characteristics**

The service area is Alachua County, which has 247,336 residents. Compared to the rest of Florida, the county has a higher percent of residents living in poverty and more minority (black) residents. Twenty percent of the population is uninsured and among those with incomes below 200% of FPL, 32% are uninsured. In June 2012, the county had 34,308 Medicaid beneficiaries. The US Census Bureau estimated that in 2009 there were 4,297 children who were eligible for Florida KidCare but not enrolled.

In 2010, area residents were responsible for 28,200 avoidable emergency room visits and 2,670 avoidable hospitalizations. The recently completed Alachua County Community Health Profile (CHP) was reviewed by a committee of community leaders who recommended the Community Health Improvement Plan include improving diabetes management as a priority. The CHP demonstrated that, despite the fact that prevalence of diabetes in Alachua County is in the lowest quartile for the state, the number of in-patient hospital admissions due to diabetes has been increasing, (it was 56 in 2007 and rose to 200 in 2010) and the mortality rate from diabetes is higher than the state rate. In addition, survey data show self care of diabetes is worse than the state average and has declined in Alachua County residents between 2002 and 2010.

The applicant offers a wide variety of personal health services, including primary care for adults and children, immunizations, testing and treatment for sexually transmitted diseases, family planning, foreign travel education and immunizations and comprehensive services for people with HIV/AIDS. In FY2010-2011, the primary care program provided care to 7,541 adults and 3,105 children. Among adults, 42% of visits were covered by Medicaid, 18% were paid by other third party coverage and 40% of visits were to uninsured individuals. Among the children, 83% of visits were covered by Medicaid, 4% were paid for by other third party payers and 13% were

to uninsured children. The current population receiving primary care is 43% white, 46% black and less than 1% were other races.

9. Organizational Chart and point of contact

The point of contact is:
Diane Dimperio: Diane_Dimperio@doh.state.fl.us Phone: 352-334-8814
The organizational chart is included as Attachment One.

10. Proposed budget for funding detailing the request. The budget is shown in Attachment I.

The personnel costs include salaries and fringe and include: one full time administrative assistant who will triage phone calls and referrals from hospitals and other providers and will ensure the incoming information on diabetic patients is handled expeditiously. A full time clerk will check patients in for clinic appointments and assist with data collection. Two full time nurses (RN or equivalent) will provide direct patient medical care, client education and exit interviews with the patients, liaison with the case managers and diabetes managers and answer medically related questions when patients call or email. The two LPNs (or equivalent) will draw blood and take measurements and assist with client assessment, education and follow up. The provider will be a full time nurse practitioner or PA. The full time case manager will work with clients who are medically low risk to assess their needs for social and medical services and help them access these. The diabetes manager will provide education and case management for patients whose diabetes is not well controlled. (The current proposal funds one full time staff and the currently funded LIP program funds one full time equivalent (FTE) so the total team effort will be two FTEs.) The full time mental health counselor will screen and provide counseling for patients who have depression and other mental health issues. The part time coordinator will be responsible for program development and oversight, and integration into the ongoing LIP program. The staff assistant will be responsible for collecting the data on program effectiveness, including administering the satisfaction surveys and conducting follow up to ensure that services provided by other providers is paid for and entered into the data system.

The budget includes lab tests and specialty services for uninsured patients who are not eligible for services provided by local resources such as We Care. For example, the We Care program does not have sufficient resources for preventive visits, so routine eye exams will be paid for from LIP funds. Although critical to maintaining good health, low income uninsured individuals with diabetes cannot afford the test strips needed for monitoring their glucose levels. The program will provide meters and up to 90 strips a month.

The budget includes an allocation for medical and related equipment and supplies for the clinic and the patient. The clinic needs a scale that will weigh people who weigh more than 300 pounds. Patient supplies include blood pressure cuffs, coolers for those who live without electricity and need to keep their insulin cool and batteries for the meters for individuals who cannot afford them. Additional funds are included for office supplies, education materials, the purchase and monthly bill for the team Blackberry. Indirect costs of 25% will be donated by the applicant.

11. Provide a brief summary of your proposed project.

The proposed project will be a pilot project demonstrating the benefits and feasibility of offering care to patients using the Patient Centered Medical Home Model. This funding would offer the ACHD the opportunity to update the medical care it provides to vulnerable populations to reflect the principles outlined in the document "Joint Principles of the Patient Centered Medical Home", developed by the American Academy of Family Physicians and other nationally recognized medical organizations. The principles, developed with the private sector as a reference point, will be adapted to the needs and resources of a public health service model.

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care that facilitates partnerships between the provider and the patient and, when appropriate, the patient's family. It has been shown to improve patient outcomes, including higher immunization rates, fewer medical errors, reduced emergency room visits, fewer hospitalizations and reduced health care costs. It also improves provider satisfaction.

The pilot project will begin the transition by ACHD to the PCMH model by implementing the core principles in the medical care offered to adult patients who have diabetes.

Personal provider – Diabetic patients will all be assigned to a provider, who will see them at each visit and establish an ongoing relationship with the patient. This provider will have the skills and ability to provide first contact, continuous and comprehensive care, as well as the commitment to work within the PCMH model.

Provider directed medical practice – The provider will work with a team of professionals at the practice level who collectively take responsibility for the ongoing care of patients. The team will include intake clerks, nurses, LPNs, a care coordinator/case manager, diabetes disease managers and a mental health counselor. The nurses and physician will be responsible for identification of clients and medical management of the diabetes. The diabetes management staff will provide care coordination and work on education and support of the home/self management of the patients who are, at program entry, poorly managed. The care coordinator will provide ongoing care coordination for patients not enrolled in disease management and will have the medical records clerk make routine calls to patients to remind them of their appointments. The pilot will also explore the benefits of offering group visits, a strategy recommended by the Florida Academy of Family Physicians that has been very successful in other practices such as Florida Diabetes Master Clinician Program, UF Diabetes Self-Management Program and The Diabetes Center at the North Florida Regional Medical Center. The mental health counselor will provide counseling for depression and other mental health issues that accompany diabetes and other chronic diseases, and will also provide group support.

The team will meet at least once every two weeks to discuss patients, barriers to care and system issues that need to be addressed. The disease managers and mental health counselor will have private offices but the other team members will be co-located to facilitate teamwork and communication.

Whole person orientation – The team will be responsible for providing and coordinating the patient's health care during all stages of life and medical needs. This includes acute care, chronic care, preventive services and end of life care.

The care will be coordinated across all elements of the health care system. When the patient needs pharmacy, lab tests and/or specialty care, the team will ensure that the patient understands the importance of getting the care and has the resources needed to obtain the

services. For example, uninsured patients needing specialty and hospital based services will be referred to the We Care program and the care coordinator/disease manager will help the client with the application process. The program will have bus passes and gas cards to help overcome transportation barriers. When the clinic receives data from these referrals, the team nurse or LPN will review the results and discuss any issues with the provider. The nurse or disease manger will follow up with the patient as needed.

The hospital sends discharge information on all patients who are seen at the emergency room or hospitalized. Discharge summaries on patients will be accepted by the team clerk and reviewed by the team nurse and provider. The patient will be contacted for a status update and scheduled for a follow up clinic visit as needed. The team will review the issue that resulted in use of hospital services and decide the appropriate course of action (e.g. change of care plan, medication change etc).

Since most of the patients are low income, the care coordination staff will be familiar with community services such as transportation, utility assistance, food resources and exercise classes. They will contact the community service as appropriate and refer patients to needed services. Uninsured patients will be screened for possible eligibility for third party coverage. In addition to the medical care team, the ACHD has on-site services to help people access food stamps and Medicaid.

Quality and safety will be hallmarks of the services offered to patients. The team will employ a care planning process driven by a compassionate and robust partnership between physicians, patients and the patient's family. All team members will advocate for their patients to support the attainment of optimal, patient-centered outcomes. The clinical disease management will rely on evidence-based medicine and clinical decision support tools, such as the recently updated Diabetes Protocol. The protocol includes a summary of guidelines for assessment and management of the adult patient with diabetes.

Continuous quality improvement (QI) will be applied to the services rendered using two strategies. During the bimonthly case management meeting, the team will review individual client issues at the request of any team member, as well as review of any patient who has used a hospital emergency room or in-patient services. At the program start and every six to eight months thereafter, the team will review population level summaries from the Health Management System that describe visit frequency and key biometrics. Both the quantitative and qualitative QI activities will support the team's engagement in performance measurement and result in development of improved processes. In addition to the review outcome data, patients will be surveyed to determine their satisfaction with the program, including the perception of their role in decision-making and the program's efforts to include family members (when appropriate).

Enhanced access to care will be supported through several mechanisms.

- Before every scheduled visit, the case manager or medical record clerk will contact the patient to remind them of the visit and help them arrange for resources needed to attend, if necessary.
- The clinic offers 24-7 phone triage for patients needing consultation for symptoms or answers to questions after hours. Calls from the pilot participants will be handled by the on-call nurse who will notify the team of the call (and the reason) on the next business day. The team nurse or other appropriate team member will contact the patient for a status update and follow up.

- The patients will have access to open scheduling, which means they will be able to schedule visits in advance or will be able to come in on a same day/next day basis if needed.
- The case manager will carry a mobile device and patients will be able to call, text or email and ask for help or information. This will allow the patients to have enhanced communication with the provider team.

12. Describe plan for identification of participants for inclusion in the population to be served in the project.

The patients served by the project will be those enrolled in adult primary care at the ACHD. The data system reports show that in the most recent 12 months, 799 adults have been seen in the clinic who have a diagnosis indicating they have diabetes. This population will be included in the project and will be enrolled in the PCMH pilot. They will receive a pamphlet describing the program and a card with the phone number of the case manager. Those with the HgbA1cs higher than 7 will be enrolled in the diabetes management component and the rest will be working with the case manager. All the patients will be screened by the mental health counselor over time, but any team member can refer patients who they have identified as needing counseling for immediate access to service.

13. How will access to primary care access system services be enhanced by this project?

Enhanced access to care is a key feature of the PCMH model, as described in the answer to Question 11. The underlying premise of the model is patient engagement through a variety of mechanisms. The core element of the model is patient centeredness, which will create a sense of ownership of the health care service among patients. This empowerment will make the health care more valuable and the patients will see themselves as an investor in their health instead of a passive recipient of services.

The access will be enhanced because the patient will have a team that gets to know them over time which allows for better continuity of care. The patient will be receiving consistent messages and the team will be able to build on the patient experience. Direct access to the team by phone and email will provide the kind of response needed by diabetics to effectively manage their condition. The open scheduling and 24/7 consultation service are also a features that will enhance access to care.

Especially important among this low income uninsured population is access to disease management and mental health counseling. The disease management practice will be geared toward those with low literacy and use the principles described in the answer to Question 16. The need for mental health counseling among people with chronic diseases is well documented. They are likely to experience depression and a feeling of hopelessness. The ability to provide access to this free service on-site will assist the patient to overcome the inability to change behavior that results from struggling with the mental health issues associated with diabetes. This will facilitate the empowerment that is key to the patient’s active participation in their own care.

14. Does the enhancement include hours of operation after 5:00 pm and/or on weekends at existing sites, or the establishment of a new clinic site?

This program focuses on improving access to care offered at our current location. It does not add a new clinic site nor extend hours of operation.

15. Describe your capability to serve minority and culturally diverse populations.

ACHD offers services that are culturally and linguistically appropriate for the clients it serves. The concept of culture includes language, gender, socio-economic status, sexual orientation, physical and mental capacity, age, religion, housing status and regional differences. Organizational behaviors, practices, attitudes and policies across all ACHD functions and facilities respect and respond to the cultural diversity of communities and clients served.

Ongoing training will be provided to enhance understanding of cultural perceptions and how staff behavior, even if well intended, may be perceived. Evaluations of clinical staff include the ability to serve a diverse client base. Staff speak a variety of languages and an in-house directory of languages spoken on-site is available to clinic staff. The greatest demand for languages in our entire facility other than English is for Spanish. According to the reports in our data management system, the primary language spoken by our primary care patients is English, with the second most common language being Spanish and one person speaking Portuguese. Three of the physicians serving primary care patients speak Spanish and a Spanish translator is available during regular clinic hours. If there is a demand for a language for which there is no on-site translation, the ACHD has access to telephonic translation services.

The ACHD currently serves a diverse population with a diverse work force. The current population receiving primary care is 43% white, 46% black and about 1% other or mixed race. In addition, almost 11% identified themselves as Hispanic. The team will be composed of a diverse group and, since diabetes is more prevalent in people of Hispanic origin, we will make every effort to recruit at least one Spanish-speaking individual.

ACHD will continue to adapt the PCMH services to ensure participation of the diverse clients and cultures in the area, including engagement of persons with limited English proficiency. ACHD hires culturally and linguistically representative staff, and provides translation services when needed.

16. Describe how you will identify and address health care diversity issues as well as health care literacy barriers:

The team of providers will be trained annually on caring for diverse populations. Their evaluations will include delivery of culturally competent health care services. This is discussed more fully in the answer to Question 15.

The patient centered care model is ideal for overcoming barriers to care and enhancing the health care experience of otherwise disenfranchised populations with health care literacy barriers. A high percent of the population that will be enrolled in the pilot are expected to have low literacy levels (i.e. many will lack the necessary health knowledge to properly treat their conditions). Without appropriate communication methods, this lack of understanding leads to increased visits to the emergency department and to decreased compliance in prescribed management plans for chronic diseases such as diabetes. ACHD will review its current health literature for information which is highly technical, complex, culturally and linguistically

inappropriate and will make any necessary changes so that the information will be easy to understand, and will encourage and motivate patients in becoming more involved in their treatment. Additionally, we will provide literature in Spanish and be prepared if a need for other languages is identified. In addition to written material, we will make information available using audio visual materials. As described above, we will have always make a staff member readily available by phone, email or in person, to answer or discuss any health/treatment related questions, so that patients have, or know where to acquire, the information they are seeking.

ACHD will develop a policy/plan that will require our staff to be trained annually on caring for diverse populations. Their evaluations will include the delivery of culturally competent and linguistically appropriate health care services, and how well they communicate with our diverse population. Moreover, we will encourage participation in and make available to our team of providers a forum for them to participate in continuing education on health literacy, cultural competence and language training, so that they may continually improve their communication skills with their patients.

In initial assessments, the staff will tactfully assess the patient's ability to read and the possible need for glasses. In educating the patients, they will use many different types of visual aids, both written and three dimensional models. The materials will be colorful, have lots of white space and use simple terms. Many of the needed materials have already been identified or developed by our existing program and are in current use.

17. Describe measures and data sources that you will use to evaluate the effectiveness of each initiative comprising your project:

The effectiveness of the program will be evaluated using biometrics including: HgbA1c, lipid and blood pressure checks, measures of renal function and BMI. These will be measured at program entry and every six months. The data will be collected from the medical record. Data will be compared over time to baseline and to goals for management.

Additional measures will indicate participation in preventive care including the number of visits for ongoing primary care, annual eye exams and receipt of recommended vaccinations. These will be available through the medical record. The final measure will be the results of the satisfaction survey collected from patients.

18. Describe data collection and reporting capabilities including systems and staffing resources, provide a **reporting template**:

The reporting template for the biometrics is shown below

Percent of Population at Goal

Measure	Baseline	6 months	12 months	18 months
BP <130/80				
LDL <100				
HgbA1c $\leq$ 7%				
BMI				
CMP				

The reporting template for participation in preventive services is shown below

Participation in Preventive Services

Measure	% Compliance		
	Year 1*	Year 2	Year 3
Preventive visits			
Eye exam			
Foot exam with sensory testing			
Dental exam			
Flu shot			

* Year 1: Oct 2012-Sept 2013

The reporting template for the satisfaction survey is shown below.

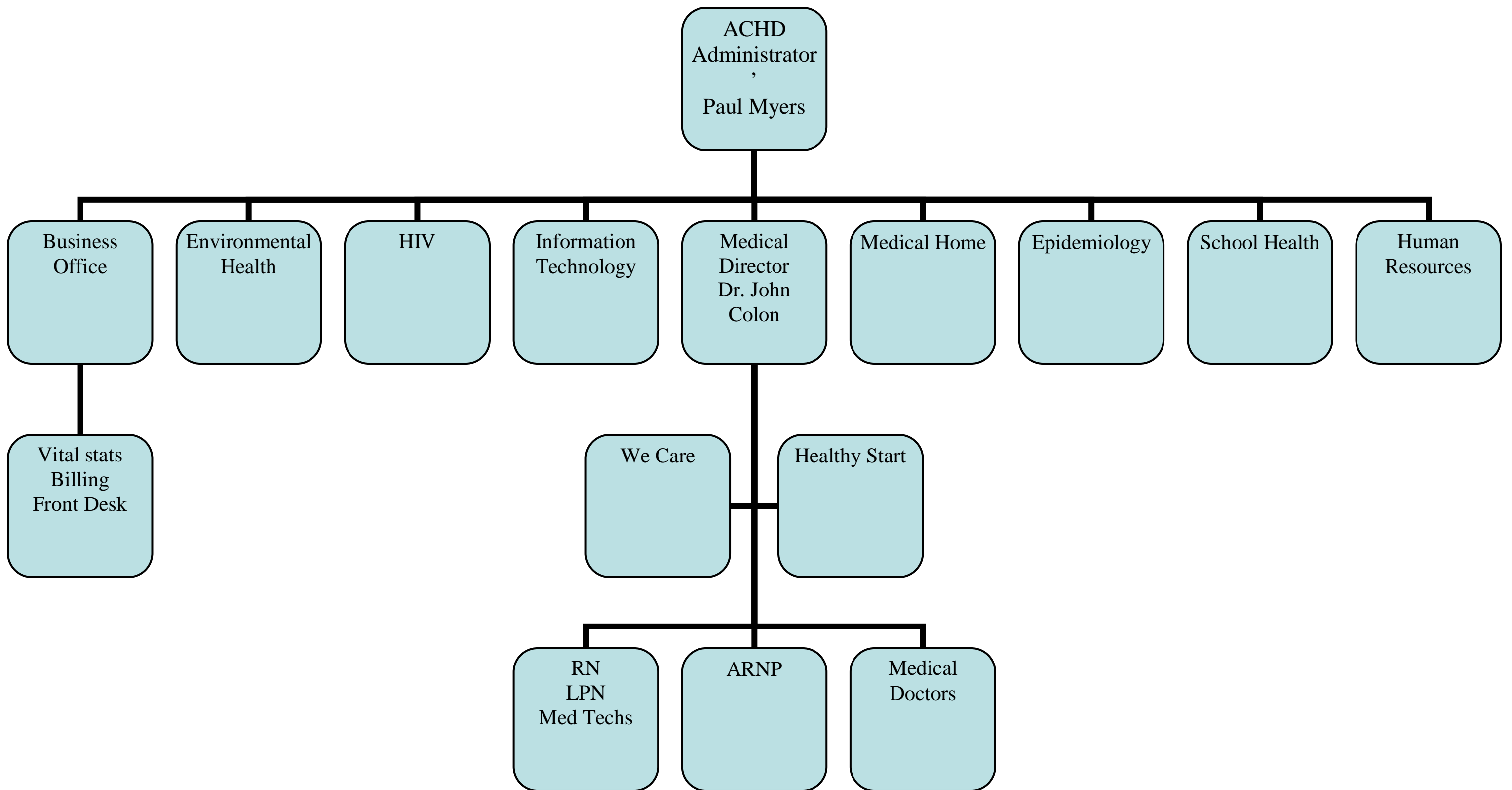
Patient Satisfaction with Medical Care

Measure	Very satisfied	Somewhat satisfied	Not sure	Somewhat unsatisfied	Very unsatisfied
	Number and percent of total choosing each answer				
Timeliness of obtaining a visit					
Time waiting during the visit					
Understanding of diabetes and care plan					
Ability to contact care team with a question or concern					
Patient perception of having a role in care					
The team is concerned about the patient as a person					
Perception of current health compared to 6 months ago					

The data on health outcomes will be collected through the electronic medical record using standard and ad hoc reports. The data on patient satisfaction will be collected using a paper and pencil survey given to clients and returned in an envelope.

19. **Provide a letter of commitment from the local match fund source on that entity's letterhead**:
    The letter of commitment for the local match is attached to the email as a PDF document.
    Please attach an excel document with your itemized budget for your project.
    The proposed budget is attached to the email.

Attachment 1
Alachua County Health Department Organizational Chart



Budget for LIP grant-ACHD		
Personnell*	**FTE**	**Amount**
Admin Assistant	1	$42,000
Medical Records Clerk	1	$42,000
LPN	2	$94,000
RN	2	$120,000
ARNP	1	$100,000
Diabetes disease manager	1	$57,000
Case manager	1	$47,000
Mental health counselor	1	$70,000
Program coordinator	0.5	$50,000
Staff Assistant	1	$37,500
Total Salary and Fringe		**$659,500**
Expenses		
Labs		$18,000
Specialty services		$10,000
Diabetic supplies		$40,000
Other medical and needed supplies		$7,500
Gas cards/bus passes		$3,500
Education supplies		$4,000
Incentives		$3,500
Office supplies		$2,000
Computers and printers		$6,655
Smart Phone		$1,200
Subtotal Expenses		**$96,355**
Total Direct Expenses		**$755,855**
Indirect Expenses		$188,964
Total Cost of Project		**$944,819**
*Amounts include salary and fringe		

July 24, 2012

Phil Williams
Assistant Deputy Secretary for Medicaid Finance
Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308

Dear Mr. Williams,

The purpose of this letter to document the Department of Health's commitment to provide the matching funds necessary to permit the participation of the Department of Health's county health departments in the 2012-13 Low Income Pool funded primary care grant opportunity as reflected in Specific Appropriation 195 of the 2012-13 Appropriations Act. The Department currently operates a number of primary care and disease management hospital alternative programs and believes we are well prepared to expand our efforts.

Alachua County Health Department is submitting a request for $755,855 to expand access to health care services for the uninsured. The Department will meet this obligation by providing the required match amount of $319,500 from state General Revenue funds appropriated by the Legislature.

Please contact me at 850-245-4036 if you need additional information.

Sincerely,

Philip Street
Senior Policy Coordinator
Health Statistics and Assessment
Department of Health