**2012-13 Low Income Pool (LIP) Tier-One Milestone (STC 61) Application**

# Application Guidelines

1. **Applicant:** Lake Health Partnership
2. **Medicaid Provider Number:** 056323401
3. **Provider Type:** Network of non-profit and public safety net providers
4. **Amount applying for:** $500,000
5. **Identify as a new or enhanced program:** Enhancement of existing program
6. **Description of the delivery system and affiliations with other health care service providers:**

The Lake County health care delivery system is centered around one of the three major acute care hospitals serving the County. In fact, the Lake County Board of Commissioners in its planning methodology has divided Lake County into three economic planning zones, which correlate with each Hospital's service area. South Lake Hospital, located in Clermont, serves south Lake County. Leesburg Regional Medical Center, located in Leesburg, serves northwest Lake County. Florida Hospital Waterman has north Lake County as its primary service area. There is also a dedicated behavioral health hospital, LifeStream, which is located in Leesburg.

The Lake Health Partnership is a unique collaborative network of six non-profit and public agencies dedicated to providing medical and dental care to low income uninsured or underinsured residents of Lake County. The partnership targets residents between the ages of 18-64 who account for 60% of emergency room utilization. The partners offer a medical home for those without a family doctor, disease management for diabetes and other chronic conditions, and assistance with accessing specialist services. Together, they coordinate care, help improve health outcomes, and provide care in the most cost-effective way.

Prior to the creation of Lake Health Partnership, Lake County's health care safety net was fragmented with the uninsured facing a severe shortage of primary care medical homes, minimal access to specialty physician services and limited access to adult dental care. Care was episodic, disconnected, lacked case management, and often led to avoidable use of hospital emergency room for needed care, due to limited safety net provider capacity.

The proposed primary care access expansion shall build on the Lake Health Partnership initiative's successes over the past two years:

- Medical Emergency Room Diversion: Diverted **4,793** encounters, resulting in savings of **$15,628,391** in savings to local hospitals (based on the average cost of a medical emergency room visit in Lake County).
- Dental Emergency Room Diversion**:** Diverted **96** encounters, resulting in. **$62,201** in savings to local hospitals (based on the average cost of a dental emergency room visit in Lake County).
- Provided primary care medical homes for **2,322** frequent and chronic users of hospital emergency rooms for avoidable Ambulatory Care Sensitive (ACS) conditions.
- Connecting **528** frequent ER users to a partner agency for continuity of care.
- Served **4,353** unduplicated clients with a total of **15,184** medical/dental encounters and **57,173** services, including referrals to specialty care.

The Lake Health Partnership proposes to enhance primary care in the most underserved zone of Lake County, commonly referred to as north Lake County by providing an additional primary care site. The Gateway Community Health Network/Umatilla Health Center is a FQHC Look-alike, and it serves north Lake County. It is a one-stop comprehensive public health, WIC, and primary care site.

7. **Service Area:** North Lake County, Florida

8. **Service Area characteristics (including demographics or population served and distribution of current population served by funding source, e.g., Medicaid, Medicare, Uninsured, Commercial insurance, etc.):**

The clinic's service area is a HRSA-designated Medically Underserved Population and a Health Professional Shortage area in the areas of primary care. Particularly for the low income population, this designation documents a shortage of health care providers as well as the existence of barriers to accessing care including lack of public transportation, travel time and distance to the next source of undesignated care and high poverty.

North Lake County has a population of 110, 527, of which 35,507 are below 200% of the poverty level, and 12,762 are below the federal poverty level:

| ZIP | Community | Population | Below 100% | Between 101 and 150% | Between 151 and 200% | Below 200% | % below 200% |
|---|---|---|---|---|---|---|---|
| 32102 | Astor | 2,679 | 391 | 525 | 267 | 1,183 | 44.2% |
| 32702 | Altoona | 3,432 | 178 | 413 | 428 | 1,020 | 29.7% |
| 32726 | Eustis | 20,192 | 2,919 | 2,347 | 2,071 | 7,337 | 36.3% |
| 32736 | Eustis | 9,947 | 1,036 | 816 | 633 | 2,486 | 25.0% |
| 32757 | Mount Dora | 23,779 | 2,999 | 2,181 | 1,998 | 7,177 | 30.2% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 32767 | Paisley | 2,837 | 687 | 404 | 229 | 1,320 | 46.5% |
| 32776 | Sorrento | 11,501 | 639 | 1,136 | 1,217 | 2,992 | 26.0% |
| 32778 | Tavares | 18,659 | 1,698 | 1,826 | 2,133 | 5,658 | 30.3% |
| 32784 | Umatilla | 12,102 | 1,657 | 1,368 | 1,771 | 4,797 | 39.6% |
| 34705 | Astatula | 2,657 | 282 | 311 | 404 | 997 | 37.5% |
| 34737 | Howey in the Hills | 2,742 | 183 | 204 | 153 | 540 | 19.7% |
| | | | | | | | |
| **Subtotal - Pct.** | | 110,527 | 12,672 | 11,531 | 11,304 | 35,507 | 32.1% |

Lake County has an uninsured population of 24.2%, according to the Census Bureau's Small Area Health Insurance Estimates. Medicaid enrollees number 44,029 and 14.4% of the Lake County population (2010 data). The Medicare population was 26.4%, and reflects the influence of The Villages, located in the northwestern part of the County.

In 2011, a community-based effort was initiated to conduct a number of assessments of the local health system assessment and gauge overall community health. The report identified the top ten leading causes of death in Lake County as 1) Cancer, 2) Heart Disease, 3) Chronic Lower Respiratory Diseases (CLRD), 4) Unintentional Injuries, including motor vehicle accidents, and 5) Stroke 6) Alzheimer's Disease 7) Diabetes 8) Suicide 9) Liver Disease and 10) Hypertension in 2009. The report highlighted the north-east quadrant of the county encompassing ZCTAs 32102 Astor, 32702 Altoona, 32767 Paisley, 32720 Deland and 37736 Eustis as experiencing a geographic disparity for various causes of mortality.

The study highlighted death rates appear to be higher in the northern portion of the county and also specifically identified the following barriers to individuals obtaining access to healthcare in the county.

- affordability of care
- being uninsured and underinsured
- some individuals live in remote rural areas or areas removed from population and services concentrations
- not enough Medicaid and Medicare providers (especially specialties)

Additionally, lack of comprehensive primary care medical homes leads to inappropriate and avoidable use of hospital ERs, and often to avoidable hospital admissions for conditions which could have been prevented or managed had a primary care medical home been available. North Lake County's avoidable ED visit rates per thousand are 28% higher than Florida's average rates:

| Lake County Avoidable Emergency Department Visits<br>Based on 2009 Data | | | | |
|---|---|---|---|---|
| ZIP | Community | Population | Avoidable ED Visits | Rate per 1000 |
| 32767 | Paisley | 2,872 | 920 | 320.3 |
| 32726 | Eustis | 21,017 | 4,827 | 229.7 |
| 32702 | Altoona | 3,336 | 761 | 228.2 |
| 32102 | Astor | 2,746 | 611 | 222.6 |
| 32784 | Umatilla | 11,750 | 2,353 | 200.3 |
| 32778 | Tavares | 18,491 | 3,079 | 166.5 |
| 34705 | Astatula | 2,633 | 431 | 163.7 |
| 32757 | Mount Dora | 23,033 | 3,762 | 163.3 |
| 32776 | Sorrento | 11,101 | 1,484 | 133.7 |
| 32736 | Eustis | 9,741 | 1,300 | 133.5 |
| 34737 | Howey in the Hills | 2,789 | 335 | 120.2 |
| | | | | |
| **North Lake** | Total - Average | **109,509** | **19,863** | **181.4** |
| | | | | |
| Florida | Total - Average | **19,021,613** | **2,700,734** | **142.0** |

(Source: 2012 Lake County MAPP Technical Appendix Report. Prepared by WellFlorida Council)

These issues were underscored in the Mobilizing for Action through Planning and Partnerships (MAPP) process, which has been recently concluded for Lake County. Two of the four top priority issues in the Community Health Improvement Plan, which is an offshoot of the MAPP, underscore the need for the LHP primary care expansion:

1. ***Need for increased specialty (including mental health providers) and general/primary care safety-net services***. (3 Key Issues a-c Below)
    a. Need to bring more providers to Lake County.
        i. Lower physician/dentist ratios than state averages.
        ii. Less economic opportunity compared to other key competitor areas.
        iii. Difficult to recruit providers to Lake County due to other non-economic, societal and cultural issues.
        iv. Lack of specialty care (especially for safety net patients) drives inappropriate utilization of emergency departments at hospitals.
    b. Reluctance of a substantial number of physicians and providers to accept Medicaid, especially for specialty care.
    c. Integration of care and continuum of care, especially for safety-net clients, is fragmented in Lake County.

2. ***Inappropriate utilization of healthcare.*** (4 Key Issues a-d Below)
    a. Lack of a central source of knowledge of alternatives (for patients/users and providers) and when and how to utilize those alternatives.
    b. Inability to reach groups that need services or education the most.

c. Lack of knowledge about the effects (and costs) of poor individual choices to the individual and to the overall community and healthcare system.
d. Lack of ability to pay or afford regular care or preventive care results in inappropriate utilization.

(Source: Lake County's MAPP Health Needs Assessment. Prepared by WellFlorida Council, July 16, 2012)

## 9. Organizational Chart and point of contact:

Point of Contact:

Donna Gregory, R.N., MS, *Administrator*
Lake County Health Department
phone: (352) 589-6424
email: Donna_Gregory@doh.state.fl.us

Organizational Chart:

*See next page*

## Lake Health Partnership Organizational Chart

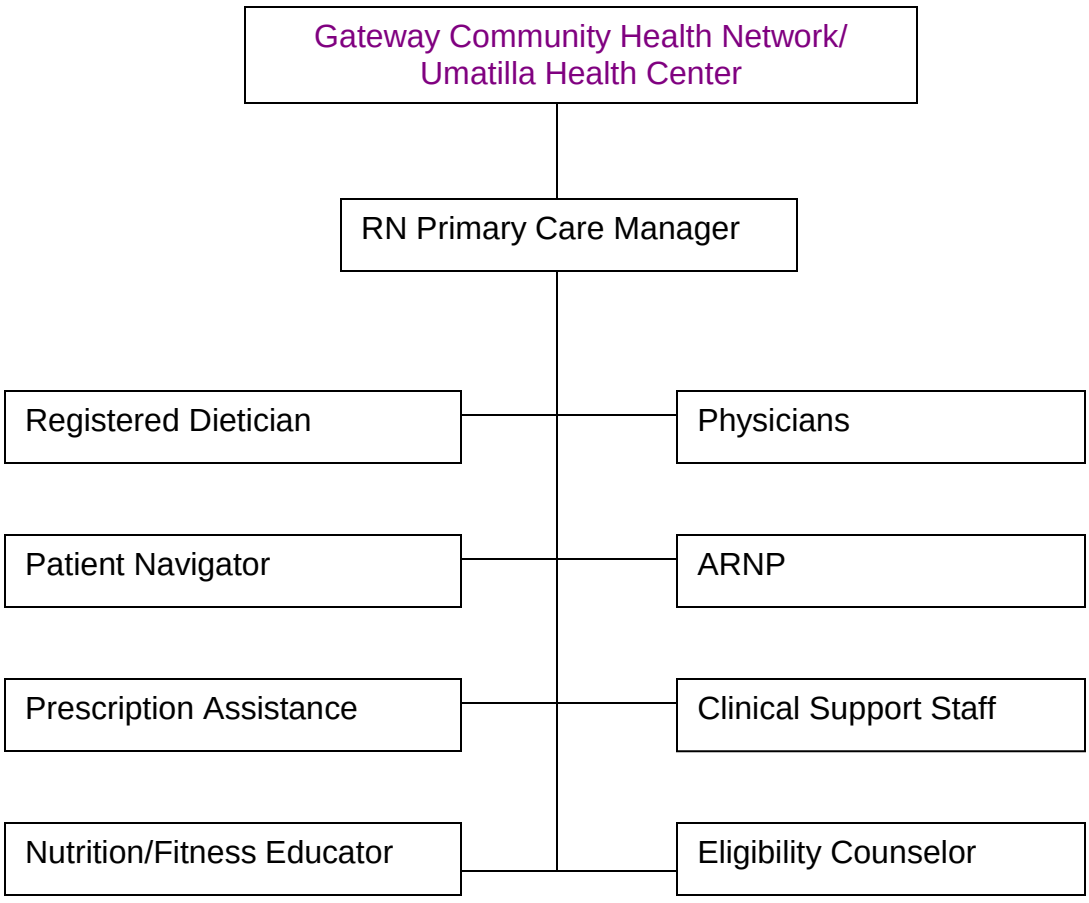
for expanded primary care at the

Gateway Community Health Network/Umatilla Health Center

**Lake Health Partnership**

Community Medical Care Center of Leesburg
Florida Hospital Waterman Community Primary Health Care Clinic
South Lake Health Clinic
St. Luke's Medical and Dental Clinic
Lake County Health Department
We Care of Lake County

***New*** Gateway Community Health Network/Umatilla Health Center



## 10. Proposed budget for funding detailing the request:

### Budget Overview

### Lake Health Partnership Primary Care Enhancement for North Lake County

The budget overview for this project assumes that primary care medical homes will be provided for 1,000 patients; and that comprehensive multidisciplinary care and care management services will be expanded to serve 1,000 patients and hospital referred clients in north Lake County.

### Services provided

We estimate that the medical providers will have 5,000 clinic visits on an annual basis. We estimate that another 5,000 care and case management visits and services will be provided by the multidisciplinary care and case management team. This would include individual, peer, group, and outreach face-to-face encounters.

### Revenues

The expected LIP enhanced primary care funding requested is $500,000.

### Expenses

On the expense side we have aggregated the cost of providing medical services and care and disease management services as follows:

| | | | | | |
|---|---|---|---|---|---|
| Physicians | 0.9 | $ | 179,797 | **$** | **161,817** |
| ARNP | 0.8 | $ | 95,546 | **$** | **76,437** |
| Nutrition/Fitness Educator | 0.5 | $ | 38,120 | **$** | **19,060** |
| RN Care and Case Manager | 1.0 | $ | 65,000 | **$** | **65,000** |
| Prescription Assistance | 0.2 | $ | 46,800 | **$** | **9,360** |
| Eligibility Counselor | 0.5 | $ | 41,019 | **$** | **20,510** |
| Registered Dietician | 0.3 | $ | 80,000 | **$** | **20,000** |
| Patient Navigator | 1.0 | $ | 42,184 | **$** | **42,184** |
| Clinical Support Staff | 1.8 | $ | 47,574 | **$** | **85,633** |
| **Project Staffing Costs** | **7.0** | | | **$** | **500,000** |

The average annual per user LIP grant cost would be $323.87. The average per user annual primary care medical visit cost charged to this enhanced primary care program would be $64.78 ($323,887 divided by 5,000 visits). This compares to the fully allocated Lake County ED cost of $3,261 per visit, and reflects a substantial cost saving per client visit.

The care and case management cost per user would be $176.11. The average cost per care and case management encounter would be $35.23 per visit. Chronic disease and medical condition management clients would be expected to access services between three to five visits per year. This would be the average cost of face-to-face, peer, and group management visits.

**11. Provide a brief summary of your proposed project:**

The Lake Health Partnership's north Lake County enhanced primary care services will be located at the Gateway Community Health Network/Umatilla Health Center. The Gateway Community Health Network/Umatilla Health Center is a FQHC Look-alike, and it serves north Lake County.

The enhanced primary care expansion would be focused on three broad goals and objectives:

- Establishment of patient-centered primary care medical homes for up to 1,000 additional clients, offered through a medical provider team of board certified Internal Medicine and Family Practice physicians and an Advanced Registered Nurse Practitioner (ARNP).

- Provision of access to comprehensive outcome based multidisciplinary disease and medical condition management services for up to 1,000 patients and residents with chronic illnesses in north Lake County.

- Reduction of avoidable hospital ER and impatient utilization by persons with Ambulatory Care Sensitive (ACS) who are uninsured or low income, and do not have a routine source of primary care in an outpatient setting.

This total project enhancement cost would be $500,000. That cost would support the additional primary care providers and multidisciplinary care and case management staff.

This project enhancement is expected to offer safer, more effective, timelier, more equitable and more patient-centered care for participants and the residents of north Lake County through access to primary care medical homes. The general population's health should also be improved by availability in the project's disease prevention and management focus on improving nutrition; increasing the right types of activities and exercise to improve fitness; and emphasis on reducing unhealthy and risky behaviors, such as substance abuse. And finally, the project aims to reduce avoidable utilization and costs of hospitals in serving north Lake County residents.

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

The new Gateway Community Health Network/Umatilla Health Center will incorporate daily contact between a new LIP RN Primary Care Program Manager and ED managers of the two major hospitals serving north Lake County to identify persons without a routine source of primary care, who are utilizing EDs for avoidable chronic care conditions, to offer a primary care medical home.

There will also be printed brochures and multimedia marketing of the new enhanced services. These efforts would be coordinated through the Lake Health Partnerships public information services that are coordinated by the Lake County Health Department.

Gateway Community Health Network/Umatilla Health Center has developed a continuity of care agreement with Florida Hospital Waterman (FHW). FHW's new hospitalist group, effective August 1, 2012, will be medically responsible for uninsured and low income clients, who present at the ED or are admitted. They will identify persons with no primary care medical homes, and offer them referral to the Gateway Community Health Network/ Umatilla Health Center (UHC). Additionally, UHC will reserve next day patient slots for persons who present at FHW with ACS non-emergency conditions, which the FHW hospitalist group can offer as an alternative to emergency treatment.

In addition to hospital referrals, the Lake Health Partnership member entities, and Lake County safety net providers would serve as other major referral sources. United Way's 211 program will be a major referral source as well. The Lake County Health Department's public health services clients will also be apprised of the availability of enhanced primary care and disease management services at the Gateway Community Health Network/Umatilla Health Center.

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

The expansion will address a continuing shortage of primary care physicians in Lake County. Lake has 30.4% fewer primary care physicians than Florida as a whole:

| Physician ratios per 100,000 population | 2009-10 | | |
|---|---|---|---|
| Type of Physician | Lake County | Florida | Variance |
| Family Practice Physicians | 19.1 | 19.7 | -3.0% |
| Internists | 28.0 | 41.8 | -33.0% |
| OB/GYN | 5.1 | 7.9 | -35.4% |
| Pediatricians | 6.2 | 14.9 | -58.4% |
| Total Physicians | 167.5 | 300.6 | -30.7% |

(Source: Florida CHARTS)

This project would add two physicians, one Internal Medicine and one Family Practice (0.9 FTE), as well as an ARNP (0.9 FTE). The project and multidisciplinary care and case management team would be coordinated by a full time RN Primary Care Program Manager, and would include a 0.25 FTE Registered Dietician Diabetic Educator, a 0.5 FTE Nutritionist/Fitness Educator, a 0.25 FTE full time Prescription Assistance Coordinator, an eligibility counselor, and a full time Patient Navigator.

Florida Hospital Waterman, the north Lake County area hospital, believes that this enhanced primary care program will open up primary care medical homes for individuals and families who struggle to find accessible primary care. These medical homes and comprehensive disease management will go a long way in reducing avoidable hospitalizations and emergency department utilization in all Lake County's hospitals.

**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 enhancement incorporates a new site in the most medically underserved area of Lake County. Patient appointments are available beginning at 7:30 A.M. for clients who work and can only be seen early. Additionally, patient appointments are available until 6:00 P.M. on Wednesdays in conjunction with a youth clinic.

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

The Gateway Community Health Network/Umatilla Health Center enhanced program is uniquely positioned to meet the minority and cultural diversity represented by the medically underserved populations within north Lake County. The medical staff, eligibility, front office, laboratory, nursing and clinical support staff also are proportionate to the ethnic and racial breakdown of the county.

The facility and all services are physically accessible to disabled individuals and the department has an established auxiliary aids plan to provide appropriate auxiliary aids to persons with impaired sensory, manual or speaking skills where necessary. Auxiliary aids may include, but are not limited to, interpreters for hearing impaired individuals, taped or Braille materials, or alternative resources that can be used to provide equally effective services. For those with limited English proficiency, the department employs a number of bilingual staff, to offer additional assistance and uses a real-time translation service when needed.

The Umatilla site also has access to telephonic medical interpretation services for other languages, should the need arise. There are especially trained signing volunteers also available to assist the hearing impaired

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

The Lake County Health Department will incorporate its health care diversity and health literacy efforts into the enhanced primary care services at the Gateway Community Health Network/Umatilla Health Center. These efforts are based on current Department of Health standards, and include grading of all materials for reading and comprehension levels. All materials use plain language initiative guiding principles, to help ensure the presented information is clear and understandable.

There is a concerted effort to assure that as many of the materials and information available to the clients, whether posted, printed, or multimedia are available in Spanish as well as English. The clinic staff has created improved Spanish versions of all materials that require completion and feedback, such as assessment forms and satisfaction surveys.

The web access for the Umatilla site also has an internal capability to be translated into a number of languages, and as processes are formalized, any materials that lend themselves to maintenance on the website, and being readily downloaded, are posted on the site and its SharePoint portals.

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

The measurement resources to evaluate effectiveness of the project shall include:

- Primary Care Medical Home – 1,000 patients – Each primary care medical home client will be formally enrolled and the number shall be tracked within the Health Management System (HMS), which is currently the practice management and clinical services tracking software utilized by the Gateway Community Health Network/Umatilla Health Center. The status will be formally reported on a monthly basis to the Lake Health Partnership.
- Care and Case Management – 1,000 patients - Each care and case managed primary care medical home client will be formally enrolled and the number shall be tracked within the HMS, and reported on a monthly basis to the Lake Health Partnership.
- Emergency Room Reduction – The Gateway Community Health Network/Umatilla Health Center will incorporate the Lake Health Partnership's current tracking tools. The baseline for tracking will be the number of avoidable ED visits in the previous participating hospital's fiscal year. There will be two additional evaluation measures. One will be tracking the health seeking behaviors and hospital ED use of persons who are formally enrolled in primary care medical homes. The other would be tracking the ED utilization of clients formally enrolled in disease and care and case management services. The goal would be a reduction in avoidable ED visits of at least ten percent (10%) for enrolled clients. Hospital ED and executive leadership will be polled on a

monthly (ED) or quarterly (executive) basis to monitor the effectiveness of ED reduction efforts.

- Client satisfaction will be measured through offering participation in client satisfaction surveys, as is the case currently for all the Lake Health Partnership collaborators.
- The overall effectiveness of the enhanced primary care at the Gateway Community Health Network/Umatilla Health Center will also be measured by incorporating FQHC (Federally Qualified Health Center) Clinical Outcome Measures to assess the quality and comprehensiveness of primary care medical home and disease management efforts.

| Number | HRSA FQHC Clinical Measures |
|---|---|
| 1 | **Percentage of pregnant women beginning prenatal care in the first trimester** |
| | **Numerator:** All female patients who received perinatal care during the program year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider.<br>**Denominator (Universe):** Number of female patients who received prenatal care during the program year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed. |
| 2 | **Percentage of children with 2nd birthday during the measurement year with appropriate immunizations** |
| | **Numerator:** Number of children in the "universe" who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate, prior to or on their 2nd birthday, among those children included in the denominator.<br>**Denominator (Universe):** Number of children with at least one medical encounter during the measurement year, who had their second birthday during the measurement year prior to or on December 31, who did not have a contraindication for a specific vaccine. This includes children who were seen for the first time in the clinic prior to their second birthday, regardless of whether or not they came to the clinic for vaccinations or well child care. |
| 3 | **Percentage of children with 2nd birthday during the measurement year with appropriate immunizations** |
| | **Numerator:** Number of children who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), 4 Pneumococcal conjugate, 2 HepA, 2 or 3 RV, and 2 influenza vaccines prior to or on their 2nd birthday whose second birthday occurred during the measurement year, among those children included in the denominator.<br>**Denominator:** Number of children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, who did not have a contraindication for a specific vaccine. |
| 4 | **Percentage of women 21 -64 years of age who received one or more Pap tests to screen for cervical cancer** |
| | **Numerator:** Number of female patients 24-64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.<br>**Denominator (Universe):** Number of female patients 24-64 years of age as of December 31 of the measurement year who were seen |

| | |
|---|---|
| | for a medical encounter at least once during the measurement year and were first seen by the grantee before their 65th birthday. |
| **5** | **Percentage of patients age 2 to 17 years who had a visit during the current year and who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year** |
| | **Numerator:** Number of child and adolescent patients age 2 to 17 years who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year, among those patients included in the denominator.<br>**Denominator:** Number of child and adolescent patients age 2 to 17 years as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year. |
| **6** | **Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented** |
| | **Numerator:** Number of adult patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months *and*, if they were overweight or underweight, had a follow-up plan documented, among those patients included in the denominator.<br>**Denominator:** Number of adult patients age 18 years or older as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year. |
| **7** | **Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months** |
| | **Numerator:** Number of patients age 18 years and older who were queried about tobacco use one or more times within 24 months, among those patients included in the denominator.<br>**Denominator:** Number of patients age 18 years and older who had at least one medical visit during the measurement year and have been seen for at least two office visits ever. |
| **8** | **Percentage of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use** |
| | **Numerator:** Number of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use, among those patients included in the denominator.<br>**Denominator:** Number of patients age 18 years and older seen who are users of tobacco and who had at least one medical visit during |

the current year and have been seen for at least two visits ever.

| | |
|---|---|
| 9 | **NEW Percentage of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the current year** |

**Numerator:** Number of patients age 5 to 40 years included in the denominator with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication (inhaled corticosteroid) or an acceptable alternative pharmacological therapy (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained released methylxanthines) during the current year.

**Denominator:** Number of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) and who had at least one medical visit during the current year and have been seen for at least two visits ever.

**Health Outcomes/Disparities Measures**

| | |
|---|---|
| 10 | **Percentage diabetic patients whose HbA1c levels are less than or equal to 9 percent** |

**Numerator:** Number of adult patients age 18 to 75 years of age with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.
**Denominator (Universe):** Number of adult patients age 18 to 75 years of age as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria.

| | |
|---|---|
| 11 | **Percentage diabetic patients whose HbA1c levels are less than 7 percent, less than 8 percent, less than or equal to 9 percent, or greater than 9 percent** |

**Numerator:** Number adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <7%, <8%, ≤9%, or >9%, among those patients in the denominator.

**Denominator:** Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had a visit at least twice during the reporting year and do not meet any of the exclusion criteria.

| | |
|---|---|
| 12 | **Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90** |

**Numerator:** Patients 18 to 85 years of age with a diagnosis of hypertension with most recent systolic blood pressure measurement <

140 mm Hg and diastolic blood pressure < 90 mm Hg.

**Denominator (Universe):** All patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension before June 30 of the measurement year.

**13 Percentage of births less than 2,500 grams to health center patients**

**Numerator:** Women in the "Universe" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery.

**Denominator (Universe):** Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery.

***NOTE:*** The Prenatal Health and Perinatal Health performance measures (*Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients*) are the only Clinical Performance Measures that can be marked "*Not Applicable*" on an ongoing basis. Such designation requires justification regarding referral and tracking practices (required regardless of applicability) in the Comments field of the performance measure forms. These performance measures cannot be marked "*Not Applicable*" if data for the measures was provided in the most recent SAC, NAP, or BPR. Applicants that assume primary responsibility for some or all of a patient's prenatal/perinatal care services (those who have selected the first or second columns on Form 5A for these services) are required to include and report on these performance measures.

**14 Additional Clinical Performance Measures**

In addition to the above required UDS clinical measures, health centers must include one Behavioral Health (Mental Health or Substance Abuse) AND one Oral Health performance measure of their choice in the Clinical Performance Measures Form. In the BPR and SAC (for existing grantees applying to serve their current service area), grantees are expected to report on their previously developed behavioral and oral health performance measures.

- If new behavioral and/or oral health performance measures are being developed, grantees may utilize patient or agency-centered measures, based on the specific type/level of oral health or mental health/substance abuse services offered by the health center and/or on the mode of service delivery the center utilizes for these services (i.e., provided directly or via a formal written referral arrangement). For example, health centers may wish to focus on areas such as behavioral health screening, treatment, and referral or behavioral health patient outcomes. Such measures can be based on services provided by behavioral health or by primary care providers.
- When developing oral health measures, both BPR and SAC applicants are reminded that oral health screening is a required primary care service (as part of "Preventive Dental) and that the minimum requirement for behavioral health service is a formal referral.

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

The Gateway Community Health Network/Umatilla Health Center currently utilizes the State Department of Health Health's Management System (HMS), a health information system which incorporates medical practice management and health data gathering and reporting. By fall, much of the HMS will be transitioned into an electronic health record format, including e-prescribing, laboratory reporting, physician notes, standing orders, and care management.

HMS has also incorporated the Health Resources and Services Administration's (HRSA's) Federally Qualified Health Center Uniform Data Set (UDS) and clinical outcomes measurement requirements. These capabilities allow for capturing baseline clinical information and tracking outcomes through medical visits and care and case management encounters. A super bill is generated and entered into HMS after each medical or care management visit, and charts a number of clinical data (including BMI, blood pressure readings, height, weight, lab values. These form the basis for monitoring clinical outcomes.

The new Umatilla site will also incorporate the current Lake Health Partnerships encounter form information. Staff assignment of data tacking, management and reporting will be incorporated in the position descriptions of the RN Program Manager for clinical areas, and the patient navigator for demographic and administrative information.

**19. Provide a letter of commitment from the local match fund source on that entity's letterhead:**

Florida Hospital Waterman, the north Lake County area hospital, has lent their support of this much needed primary care expansion for north Lake County. The President's letter is appended to this section.

The Lake County Health Department acts as the fiscal agent for the Lake Health Partnership. Attached to this application, please find a letter from the Florida Department of Health committing $211,350 in qualified matching funds required by this project.

FLORIDA HOSPITAL
WATERMAN

July 25, 2012

Ms. Donna Gregory, Administrator
Lake County Health Department &
Grantee of Lake Health Partnerships
P.O. Box 1305
Tavares, FL 32778

Dear Donna,

Please consider this letter an affirmation of our hospital system's support for the Lake Health Partnerships enhanced primary care application for North Lake County. North Lake County is the most medically underserved portion of Lake County, and expanded patient-centered primary care medical homes and comprehensive disease management programs will go a long way in reducing avoidable hospitalizations and emergency department utilization in all our hospitals.

This enhanced primary care will open up primary care medical homes for up to 2,000 individuals and families, who currently struggle to find accessible primary care and maintain acceptable health status. The enhanced primary care services will also focus on reducing obesity and other underlying causes for many of the chronic diseases, whose avoidable care costs are straining hospital resources.

We welcome closer primary care case coordination between Florida Hospital Waterman and the Umatilla Health Center, which can serve as a comprehensive, multidisciplinary one-stop-shop for the underserved, especially uninsured and Medicaid populations who currently can't access other aspects of Lake Health Partnerships programs within the fee clinics.

On August 1, 2012, Florida Hospital Waterman is instituting a new hospitalist program to better manage the ER and inpatient care needs of uninsured and low income populations. We've discussed closer collaboration with the Umatilla Health Center to reduce avoidable hospital use of those presenting at our hospital without a routine source of primary care. Enhanced LIP primary care funding would solidify collaboration.

Please keep us apprised of the progress of this LIP application.

Sincerely,

Kenneth R. Mattison
President

Rick Scott
Governor

FLORIDA DEPARTMENT OF HEALTH

John Armstrong, MD
State Surgeon General

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.

Lake County Health Department, as part of the Lake Health Partnership public-private primary care initiative, is submitting a request for $500,000 to expand access to health care services for the uninsured. The Department will meet this obligation by providing the required match amount of $211,350 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