Low Income Pool (LIP) Project Application

Readmission Reduction Program at Memorial Regional Hospital

submitted by
South Broward Hospital District, d/b/a
Memorial Healthcare System

July 31, 2012

Readmission Reduction Program
at Memorial Regional Hospital

1. **Applicant**: Memorial Regional Hospital
2. **Medicaid Provider Number**: 0100200-00
3. **Provider Type**: Hospital
4. **Amount applying for**: $403,539
5. **Identify as a new or enhanced program:** New Program
6. **Description of the delivery system and affiliations with other health care service providers**: The South Broward Hospital District, d/b/a Memorial Healthcare System (MHS) has an efficient health care delivery system and strong affiliations with other health care providers. MHS provides primary and preventive health care services for the uninsured and Medicaid patients through its South Broward Community Health Services Department, which operates 5 Community Health Centers (CHCs) that are located throughout the service area. The largest CHC is located within the Broward County Health Department's South Regional Health Center in Hollywood. MHS provides referrals to the Broward County Health Department for patients with HIV disease in need of dental and pharmacy services, case management, medication, home delivered meals and medical transportation. Through a subcontract with Broward Health, MHS provides medical care for the homeless in Hallandale Beach.

MHS has entered into an agreement with the Broward Community and Family Health Center, a federally designated health center (FQHC) to assist with the provision of care with the target population. MHS provides funding for the FQHC to provide primary care services for up to 1,500 patients; while MHS provides the specialty care, emergency department and inpatient hospitalizations for these patients.

MHS has current agreements with the Broward Regional Health Planning Council, the Broward County Health Department, Hispanic Unity of Florida, along with community and faith-based organizations, to provide care through its emergency departments for the target population and also to provide a medical home for the uninsured and Medicaid recipients who meet eligibility criteria at its CHCs. In addition, MHS has entered into an agreement with After Hours Nurse Response Call Center to enhance the services offered to patients served by the CHCs.

MHS provides a wide range of health care services through its six hospitals including Memorial Regional Hospital, Memorial Regional Hospital South, Memorial Hospital West, Memorial Hospital Pembroke, Memorial Hospital Miramar and Joe DiMaggio Children's Hospital, and numerous ancillary facilities located throughout south Broward County.

The new programs being proposed for LIP funding this year will build upon MHS's efficient health care delivery system and will support the overall goals of the Three-Part-Aim: better care for individuals, better health for populations, and a reduction in per capita costs. For example, the enhanced Patient Centered Medical Home (PCMH) will enroll patients identified by the Specialty Care Coordination Program as being in need of a medical home, and PCMH extended hours will coincide with the Emergency Department Diversion Program's extended hours to cut down on operating costs. The Patient Navigators in the Emergency Department Diversion Program will work closely with the CHC staff to link patients for follow up care. The Readmission Reduction Program will identify hospital inpatients and refer them to the CHC to establish a medical home or to the Specialty Care Coordination Program for assistance with their

health issue. All the LIP initiatives will work together to enhance the delivery of care and improve health outcomes for the target population

7. Service Area: The South Broward Hospital District, d/b/a Memorial Healthcare System (MHS) is a special taxing district created by the Florida Legislature in 1947. A public, non for profit organization, MHS is governed by a seven-member Board of Commissioners appointed by the Governor of Florida. Since the opening of its first hospital in 1953, MHS has served as the safety net provider for the 135-square mile service area – southern Broward County. The mission of MHS is to provide safe, quality, cost effective, patient and family-centered care, regardless of one's ability to pay, with the goal of improving the health of the community it serves. Currently, MHS is the fifth largest public, non-profit healthcare system in the nation.

MHS consists of six hospitals, five primary care centers and numerous ancillary facilities which in 2011 provided 513,000 hospital outpatient visits, 110,000 hospital admissions and 396,000 emergency department visits. Considering this volume, the cost of healthcare for MHS's uninsured patients resulted in more than $898 million in uncompensated care.

Focus of Program - Memorial Regional Hospital

Located in the eastern portion of MHS's designated service area, Memorial Regional Hospital opened in the City of Hollywood in 1953. During the past 59 years, MRH has expanded and is now one of Florida's largest and most advanced hospitals. As the flagship facility of Memorial Healthcare System, this 553-bed hospital holds a distinguished reputation for renowned medical expertise, advanced medicine and leading-edge technology. Its Trauma Center is one of only seven Level I trauma centers statewide. The hospital's wide scope of services and programs includes Memorial Cancer Institute, Breast Cancer Center, Cardiac and Vascular Institute, Neuroscience Center, Comprehensive Weight-Loss Surgery Program, Family Birthplace, Center for Behavioral Health, Sickle Cell Day Hospital, Outpatient Rehabilitation Center, Mobile Mammography and other programs.

In 2011, the American Hospital Association honored MRH with its Quest for Quality Prize. The prize honors hospitals that have committed to achieving the Institute of Medicine's six quality aims-safety, patient-centeredness, effectiveness, efficiency, timeliness, and equity. In 2010, MHS was selected to receive the Premier Award for Quality. This award was to recognize MHS for its top performance in all six dimensions of QUEST: Cost, Evidence-Based Care, Mortality, Harm, Patient Experience, and Readmissions.

8. Service Area Characteristics

Southern Broward County consists of more than 650,000 residents. The racial and ethnic background of these persons is 33% White, Non-Hispanic, 33% Hispanic, 28% Black, Non-Hispanic and 6% Other. More than 30% of the population is foreign-born and more than 35% speak a language other than English in their home. Based on 2011 data from MHS, these individuals rely on the following healthcare funding sources: 49% Commercial Insurance, 30% Uninsured, 10% Medicare and 11% Medicaid.

The minority population in this community, many of whom are Medicaid eligible individuals (including uninsured and underinsured individuals covered under the Low Income Pool component of the Florida Medicaid waiver), are the most likely to be without health care coverage and this lack of insurance directly impacts whether an individual will have a medical home. A medical home provides a regular source of ongoing health care services. Access to care

appears to be a greater problem for Blacks and Hispanics than for other population groups. About one-third of minorities in southern Broward County do not have a medical home, compared to 21% of Whites.

This lack of a medical home is particularly troublesome for persons who have heart related conditions such as hypertension and high cholesterol, and pulmonary conditions such as asthma, chronic obstructive pulmonary disease, heart failure and pneumonia that may require ongoing, coordinated care to maintain compliance with their care regimen.

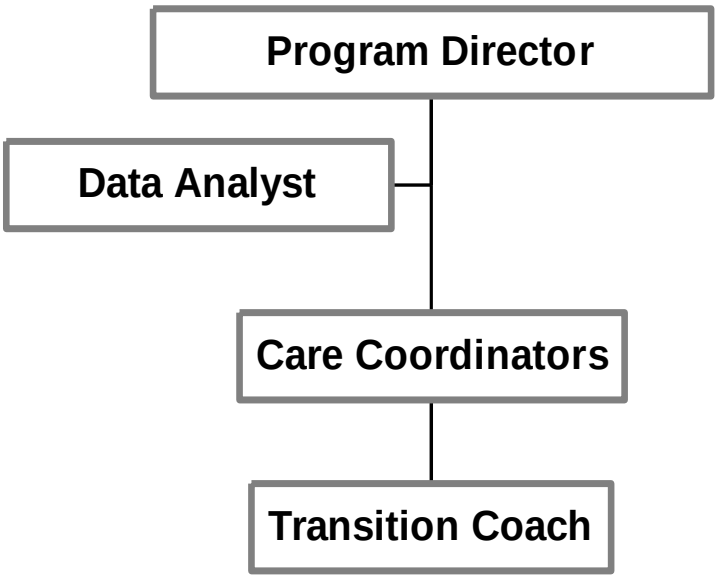
Since 1992, MHS has provided a wide scope of medical services for Medicaid eligible individuals (including uninsured and underinsured individuals covered under the Low Income Pool component of the Florida Medicaid waiver) who reside in southern Broward County through its South Broward Community Health Services (SBCHS) program. Beginning with one Community Health Center in Hollywood, MHS has added locations in West Hollywood, Dania Beach and Miramar. In 2011, MHS opened its fifth Community Health Center in Hallandale Beach.

Through the Community Health Centers, along with the adult and pediatric mobile units, SBCHS accounted for nearly 142,000 patient visits, an average of 4.6 visits per person. Services include physician visits, specialist referrals, laboratory testing, health education, immunizations, HIV testing and counseling, along with social services.

Currently, SBCHS serves the following population: 46% Hispanic, 28% Black, 18% White and 8% Other. The healthcare funding source for this population is 84% Uninsured, 11% Medicaid and 4% Commercial Insurance.

9. **Point of Contact:** Jennifer Kadis, Director of Clinical Effectiveness, Memorial Healthcare System at 954-265-5449 or Email: jkadis@mhs.net

Organizational Chart for Proposed Program:



10. Proposed budget for funding detailing the request: $403,539 with $170,575.94 in local match funds. This budget provides $216,264 in salaries, benefits and administrative expenses for hospital-based staffing to identify, educate and support patients in the target population during their inpatient hospitalization and through the discharge process. These staff members will work in conjunction with Transition Coaches who will be hired through a subcontract for $187,275. These Transition Coaches will provide in-home and telephonic support of targeted patients using the Post Acute Support System (PASS) intervention model. Please refer to **Attachment 2** for the full budget detail.

11. Provide a brief summary of your proposed project:

Access to quality health care services is vital in eliminating health disparities and increasing the quality and years of healthy life for all persons and a key element in any community health initiative. Memorial Regional Hospital (MRH) will implement the *Readmission Reduction Program* which features enhanced hospital-based support and a care transitions intervention that supports high risk patients during their hospital stay, through hospital discharge to a skilled nursing facility or home setting, including assisted living facilities. The Readmission Reduction Program (RRP) features a dedicated Care Coordinator, a Registered Nurse with case management experience, to provide in-hospital clinical support, along with a Transition Coach, who will adapt an evidence-based intervention model to provide non-clinical supportive services for up to 30 days post discharge. The program also provides a part-time Data Analyst to assist in identifying the target population and reporting.

The goal of the Readmission Reduction Program is to reduce potentially avoidable hospital readmissions and emergency department visits, improve overall quality of care and produce cost savings related to readmissions for patients who are uninsured or on Medicaid, including Fee for Service, Provider Service Network, and Dual Eligible, with no income restrictions, who have been hospitalized with Acute Myocardial Infarction (AMI), Heart Failure (HF) or Pneumonia (PNEU). This program will support the overall goals of CMS's Three-Part-Aim and Special Terms and Conditions (STC) #61 which provides: 1) better care for individuals; 2) better health for populations; and 3) a reduction in per capita costs.

Need for the Readmission Reduction Program (RRP)

Memorial Healthcare System (MHS) recognized that its hospital facilities had challenges with hospital readmissions when the Centers for Medicare and Medicaid Services (CMS) in 2011 published a document entitled, "High Readmission Hospitals" (This document is available at: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjetsEvalRpts/Downloads/CCTP_FourthQuartileHospsbyState.pdf) which documents readmission rates, 2006 to 2009, from Hospital Compare. State average readmission rates were calculated for each of the three reported conditions: AMI, HF and PNEU. Hospitals in each state were then sorted by their reported readmission rates on each of the three conditions and hospitals in the fourth (worst) quartile for each of the three conditions were selected. Nationally, a total of 138 hospitals were in the worst quartile in all three admission rates and an additional 483 hospitals had readmission rates in the worst quartile on two of the three conditions.

As listed in **Table 1** below, Memorial Regional Hospital was listed as being in the worst quartile nationwide for each of the three conditions, AMI, HF and PNEU, while Memorial

Hospital West and Memorial Hospital Miramar were listed as being in the worst quartile for two of the three conditions.

Table 1 – Readmission Percentages by Facility (Medicare Patients, 2006-2009)

HOSPITAL	AMI	HF	PNEU	DISCHARGES
Memorial Regional Hospital	21.3%	25.9%	19.7%	1,551
Memorial Hospital West		27.0%	20.5%	733
Memorial Hospital Miramar	26.7%	21.1%		204

Based on this CMS data for three of its hospital facilities, MHS began a system wide review of readmission data for AMI, HF and PNEU among all payor classes. In 2011, there were 1,430 readmissions within 30 days that resulted in 10,041 days of care that cost the system $114.8 million. Therefore, the average cost per episode was $80,279. The cases, days of care and charges are outlined in **Table 2** below. Based on this data, MHS determined that transitions from one care setting to another are often dangerous points in care for patients.

Table 2 – Readmissions for all Payors in 2011

HOSPITAL	CASES	DAYS	CHARGES
Memorial Regional Hospital	673	5,557	$62,177,317
Memorial Hospital West	418	2,622	$31,835,853
Memorial Hospital Pembroke	159	1,053	$10,531,549
Memorial Hospital Miramar	180	809	$10,334,957
Total	**1,430**	**10,041**	**$114,879,676**

Based on the data outlined above in Table 2, MHS then examined just the number of cases for the target population of persons who are uninsured or on Medicaid, including Fee for Service, Provider Service Network, and Dual Eligible, with no income restrictions, for each condition. MHS determined in 2011, there were 868 cases with a final diagnosis at discharge of AMI, HF and PNEU. These are included in **Table 3** below based on hospital facility.

In order to determine the total number of cases the MHS will have to track system wide to support all persons with a final diagnosis of AMI, HF and PNEU, MHS will increase the number of persons to participate in the RRP by 5%. Therefore, MHS will provide the RRP for approximately 911 persons each year. The column entitled Targeted Cases in Table 3, below, includes a breakdown of cases by hospital facility. Of the 911 patients who are targeted system wide at MHS facilities for the RRP, MRH will focus on approximately 461 patients at its facility. Because patient participation is voluntary, MRH expects 60% or an estimated 277 patients who meet program criteria (i.e. the number who participate in the program).

Table 3 - Readmissions for Target Population in 2011

Facility	AMI	HF	PNEU	TOTAL	5%	Targeted Cases
Memorial Regional Hospital	114	110	215	439	22	461
Memorial Hospital West	85	90	66	241	12	253
Memorial Hospital Pembroke	3	33	70	106	5	111
Memorial Hospital Miramar	4	15	63	82	4	86
TOTAL	**206**	**248**	**414**	**868**	**43**	**911**

Based on the cases, MHS then examined the percentages of 30-day readmissions for each condition at each facility. These percentages are outlined in **Table 4** below. Based on these percentages, MHS determined that an innovative, evidence-based Readmission Reduction Program could significantly enhance the quality of life and quality of care for patients while greatly improving the hospital readmission rates for the targeted population with AMI, HF and PNEU.

Table 4 – Percentages of Readmissions for Target Population in 2011

HOSPITAL	AMI	HF	PNEU	TOTAL
Memorial Regional Hospital	14% (N=16)	18% (N=20)	11% (N=24)	14% (N=60)
Memorial Hospital West	100% (N=2)	15% (N=26)	13% (N=7)	16% (N=35)
Memorial Hospital Pembroke	2% (N=0)	29% (N=26)	11% (N=7)	15% (N=35)
Memorial Hospital Miramar	25% (N=1)	33% (N=5)	10% (N=6)	15% (N=12)
TOTAL	**9% (N=19)**	**22% (N=54)**	**12% (N=49)**	**14% (N=122)**

Based on the significant number of cases and the percentage of readmissions at MHS facilities, MHS decided to conduct a pilot program at one hospital facility, Memorial Hospital Pembroke, for one of the three health conditions – Heart Failure.

Heart Failure Pilot Program at Memorial Hospital Pembroke

Based on high readmission costs for HF patients, staff at Memorial Hospital Pembroke reviewed the Project Re-Engineered Discharge (RED) evidence-based model for heart failure and formed a multidisciplinary team to develop a Heart Failure Care Coordination Pilot Program in 2010 related only to Medicare patients. Project RED is an intervention that is a patient-centered, standardized approach to discharge planning and patient education, initially developed through research funded by the Agency for Healthcare Research and Quality (AHRQ).

The multidisciplinary team reviewed statewide data on readmissions, mapped the existing discharge process, created a customized database and developed a point of entry audit tool. The team also developed treatment algorithms and performed patient chart audits of readmission treatments. The customized database includes admission, discharge and caregiver information, a 15-item baseline interview, along with medication management, a personal health record and medical care follow up.

The Pilot Program utilized a Care Coordinator to meet with the patient prior to discharge, provided the patient with education about heart disease, nutrition and community resources and created a customized discharge plan for the patient. After discharge, the Care Coordinator scheduled follow up appointments with a primary care physician and a cardiologist, provided follow up telephone calls, coordinated home health and medical equipment for the patient as needed and faxed medication reconciliation, discharge and consultant summaries to the primary care physician. The pilot program resulted in 51% fewer heart failure 30-day readmissions at MHP.

Based on the success of a pilot program, MHS also reviewed Care Transition Intervention (CTI) Program, developed by Dr. Eric Coleman at the University of Colorado. This effective intervention provides transition coaching to support patients with complex care needs and is in widespread use in the United States. This model is also on the Centers for Medicare and Medicaid's comprehensive list of evidence-based care transition interventions.

MHS will use elements of Project RED to provide in-hospital support and the Post Acute Support Service (PASS) Program, which is adapted from the CTI Program, to coordinate and manage the transition of patients from the acute inpatient setting to a skilled nursing facility or home or community setting, including assistant living facility for the proposed *Readmission Reduction Program* at Memorial Regional Hospital. The core components of the PASS Program are listed in **Table 5** below.

Table 5 – Core Components of the PASS Program

CORE COMPONENTS	
Medication Self Management	Patient is knowledgeable about medications and has a medication management system. During the home visit, the Transition Coach will conduct a face-to-face medication reconciliation.
Personal Health Record (PHR)	Patient understands and utilizes a PHR to facilitate communication and ensure continuity of the care plan across providers and settings. During a home visit, the Transition Coach will conduct a reconciliation of the PHR data and provide education.
Primary Care Physician (PCP) and Specialist Physician Follow-Up	Patient schedules and completes follow-up visits with PCP and Specialists and is empowered to be an active participant in these interactions. During the home visit, the Transition Coach will schedule and coordinate PCP and Specialty Physician follow up visits with the Specialty Care Coordination Program offered by MHS's Community Health Center.
Red Flags/Signs and Symptoms	Patient is knowledgeable about indicators that suggest his or her condition is worsening and how to respond. During the home visit, the Transition Coach will provide education and coordination of interventions.
Home and Community Based Services	During the home visit, the Transition Coach will identify and coordinate home and community based services to assist in the care transition and maintain patient independence. The transition Coach will provide referrals to community and faith-based agencies for needed resources.
Nutrition Management	Patient is knowledgeable about nutrition status, meal planning and diet as it relates to health conditions. During a home visit, the Transition Coach will complete a kitchen and environment evaluation. The Transition Coach will also complete a nutrition needs assessment to determine if there is an immediate need for post-discharge meals. The post-discharge meal intervention will provide 10 nutritious meals to the patient's home, as needed.

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

The RRP will focus on adults between the ages of 18 and 64, who are uninsured or on Medicaid, including Fee for Service, Provider Service Network, and Dual Eligible, with no income restrictions, who have been hospitalized for AMI, HF or PNEU. The RRP will apply standardized treatment and care plans, as well as enhanced discharge plans, to this target population.

Of the 911 patients who are targeted system wide at MHS facilities for the RRP, MRH will focus on approximately **461** patients at its facility. MRH hopes to achieve a 60% enrollment rate (an estimated 277 patients) that meet program criteria and agree to participate in the program.

The patient identification method is outlined in **Table 6** below and will rely on a daily review of the Inpatient and Observation Daily Census Report by the Care Coordinator. The Care Coordinator will meet with patients during their inpatient or observation visit, provide clinical coordination to ensure a smooth discharge, promote the importance of the PASS Program and link the patient with the Transition Coach. The Transition Coach will conduct a face-to-face meeting with the patient and promote the importance of the PASS Program. If the patient agrees, the Transition Coach will schedule a home visit with the patient within 3 days of discharge and provide ongoing supportive services and telephonic assistance for 30 days.

Patients who meet program criteria but are discharged from the hospital prior to a face-to-face meeting with a Transition Coach will be contacted by both the Care Coordinator and the Transition Coach. The Care Coordinator will support the patient's clinical needs, while the Transition Coach will schedule a home visit and provide ongoing telephonic assistance and supportive services for 30 days.

Table 6 – Patient Identification Method

Location	Method
Hospital	▪ Inpatient Daily Census Report – The Care Coordinator will identify members of the target population who been admitted to the hospital for AMI, HF and PNEU and link them to the Readmission Reduction Program.
Hospital	▪ Observation Daily Census Report – The Care Coordinator will identify members of the target population who are being observed but not admitted to the hospital for AMI, HF and PNEU and link them to the Readmission Reduction Program.
Home or Sub-acute Visit	▪ Hospital Discharge Report – The Care Coordinator will identify members of the target population who have been discharged without being linked to the Readmission Reduction Program. The Care Coordinator will follow up with the patient via telephone, explain the importance of the program and link the patient with the Transition Coach. The Transition Coach will provide an in-home visit (or a visit to an ALF of SNF) and provide ongoing support.

Barriers to Care for Targeted Participants

Upon discharge from a hospital facility, the target population faces the following barriers: 1) lack of knowledge about how to access follow up care with specialty physicians; 2) cost of follow up care with specialty physicians; 3) lack of transportation to follow up appointments; 4) lack of caregiver support for the health condition; 5) inability to fill prescriptions for post-

discharge medications due to cost; 6) lack of understanding about the importance of establishing a medical home with a primary care physician for ongoing care; 7) lack of reading and writing skills which make it difficult to understand and complete eligibility forms for Medicaid or the Community Health Center program; and 8) language and cultural barriers.

Based on an Institute of Medicine Report, "Language and cultural barriers have real consequences for both patients and providers. Barriers can lead to decreased access to healthcare, diminished patient comprehension and decreased patient satisfaction, compromised quality of care, and increased costs and inefficiency in the health care system."[1]

The RRP will decrease barriers faced by the target population by placing a Care Coordinator within the hospital facility. This Care Coordinator will identify patients who qualify for the enhanced RRP, screen patients for possible barriers, provide health-condition specific education to the patient, determine the risk status of the patient for readmission, schedule a follow up appointment with a cardiologist or pulmonologist, as needed, in the Specialty Care Coordination Program operated by MHS in the Community Health Center, provide ongoing monitoring of the patient and conduct extensive discharge planning for the patient and his/her caregiver. The Care Coordinator will also introduce the patient and his/her caregiver to a Transition Coach, who is a member of the Post-Acute Support Systems (PASS) Program team that will follow the patient for the next 30 days.

As outlined in **Table 7** below, the Transition Coach will work in conjunction with the Care Coordinator to ensure a timely and easy discharge process for the patient. Often, this is a confusing time for the patient and his or her caregiver as there is a great deal of information presented regarding follow up care. Together, the Care Coordinator and Transition Coach will ensure that this process is seamless and will not result in an avoidable emergency department visit or an avoidable hospital admission.

Table 7 – Role of the Transition Coach

Roles and Responsibilities
Transition Coaches will work in conjunction with the hospital-based Care Coordinator (RN) to identify members of the target population.
Transition Coaches will visit with patients, if possible, prior to hospital discharge, to screen them for the PASS Program.
Transition Coaches will enroll patients who meet program criteria in the PASS Program.
Transition Coaches will assist in the hospital discharge process.
Transition Coaches will make a face-to-face, in home visit within 3 days of discharge, as needed.
Transition Coaches will provide supportive telephone calls on days 2, 7, 14, 21 and 30 after the initial home visit for transition support, coaching and reinforcement of program components.
Transition Coaches will schedule or confirm an existing appointment at the Specialty Care Coordination Clinic (heart or pulmonary) at MHS's Community Health Center.
Transition Coaches will assist in obtaining follow up appointments with the patient's primary care physician or link patients to a primary care provider, if needed.
Transition Coaches will assist with home and community-based social support services, as needed, for 30 days.

[1] *Institute of Medicine, Unequal Treatment: Confronting Racial and Ethnic Disparities*, Washington, D.C., National Academy Press, 2002

Transition Coaches will provide a post discharge Meal Program to support nutritional needs for 10 days, as needed. If longer term nutritional support is needed, the coach will link the patient to available programs.
Transition Coaches will provide in-home medication reconciliation, as needed.

Within 3 days of hospital discharge, the Transition Coach will visit the patient at his or her home or other location (skilled nursing facility, assisted living facility) to assist with medication reconciliation, determine nutritional needs and promote self-care management, as needed. This in-home, face-to-face visit is an invaluable program component since it allows the Transition Coach to see the post-discharge living environment and determine what additional supportive services may be necessary for the patient. The Transition Coach will also make or confirm a follow up appointment with a specialty physician and a primary care physician. Many of these patients will be linked to the Specialty Care Coordination Clinics at MHS's Community Health Center for an immediate follow up appointment with a cardiologist or pulmonologist.

Following the in-home visit, the Transition Coach will assist with home and community-based social support services, as needed, for 30 days. The Transition Coach will make calls to the patient's home on days 2, 7, 14, 21 and 30 to reinforce program components and assist with any needs that could result in a hospital readmission.

The Transition Coach will work in conjunction with MHS and other healthcare providers, along with community-based and faith-based organizations to provide referrals for supportive services, including transportation, child care, utility assistance, to assist members of the target population.

The RRP will support the six priorities for improving health outcomes and increasing the effectiveness of care for all populations outlined in the March 2011 National Strategy for Quality Improvement Report to Congress by using Transition Coaches to actively engage physicians, patients and family members in developing strategies to achieve the following priorities: 1) make care safer by reducing harm caused in the delivery of care; 2) ensure that each person and family is engaged as partners in their care; 3) promote effective communication and coordination of care; 4) promote the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; 5) work with communities to promote wide use of best practices to enable healthy living; and 6) make quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models.

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

The RRP provides an enhancement to the South Broward Community Health Center Program operated by MHS which provides five Community Health Centers that are conveniently located throughout southern Broward County. The RRP also offers a direct link to two Specialty Care Coordination Clinics – one for Heart Failure and one for Pulmonary Conditions that are located within a Community Health Center. These specialized clinics offer an immediate follow up appointment with either a cardiologist or a pulmonologist. Based on the patient's needs, the physician will refer the patient to a Disease Manager, who will provide ongoing assistance for the patient following HEDIS guidelines.

Specialty Clinic staff will also conduct an eligibility assessment for possible coverage for patients through Medicaid or the Community Health Center program for the uninsured. Staff will

stress the importance of establishing a medical home and remaining compliant with the physician's plan of 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?

The RRP provides an enhancement to the existing hospital discharge process through the addition of a hospital-based Care Coordinator and a Transition Coach. The Transition Coach will meet the patient in the hospital and then provide a face-to-face meeting at the patient's home or sub-acute care setting at a convenient time, including evenings and weekends. The Transition Coach will also provide telephonic assistance throughout the 30-day post discharge process. The PASS program component will also have a call center for patients from 7am to 6pm.

In addition, the After Hours Nurse Response Call Center will be available for members of this population after regular business hours and on weekends and holidays. This enhancement is designed to provide ongoing supportive services and a link to quality, timely and effective follow up care in the Community Health Center with the goal of preventing a hospital readmission.

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

The RRP will assist in providing enhanced care to minority and culturally diverse populations who are at greatest risk for being lost to care. In the designated service area, more than 30% of the target population is foreign-born, more than 36% speak a language other than English in their home and 8.4% of households are considered to be linguistically isolated. In linguistically isolated households, all members of the household 14 years old and over have at least some difficulty with English. The majority of Community Health Center patients, 46%, are Hispanic and the level of persons who speak Creole has been steadily increasing since 2002. As a result, the target population faces language and cultural barriers to post discharge follow up care and ongoing, coordinated care.

Sociocultural barriers, which are policies, practices, behaviors and beliefs that create obstacles to healthcare access and service delivery include: 1) cultural differences between individuals and institutions; 2) cultural differences about health and illness; 3) customs and lifestyles; and 4) cultural differences in language or nonverbal communication styles.

This program will provide staff members that are representative of the target population who will provide culturally and linguistically appropriate care. This program recognizes that hiring culturally diverse staff members is vital to program success and is committed to hiring staff members who speak the languages prevalent in the target population, primarily Spanish and Creole. Staff will attempt to develop trust with uninsured persons who are culturally and linguistically diverse, have complex medical needs, remain outside organized systems of care and have insufficient resources to obtain care.

This program ensures cultural competency in the development and maintenance of interpersonal and professional skills that increase respect, understanding and knowledge of differences between the patient and the practitioner in values, lifestyles, norms, beliefs, and opportunities. MHS strives to adopt and practice cultural competence and incorporate the principles into its care planning and ongoing staff training.

This program will also ensure that all staff training promotes and reinforces cultural competency. Staff will learn that cultural competence is the ability of health organizations and staff to recognize the cultural beliefs, values, attitudes, traditions, language preferences, and

health practices of diverse populations and how to apply that knowledge to produce a positive health outcome.

Staff will also learn that the culture of patients is a leading force in shaping behavior, values and perceptions because it influences how people seek health care and how they behave toward a health care provider. Staff will learn to recognize that they must have a mixture of values and attitudes, knowledge and skills that help them establish trust and communicate with patients of other cultures. Staff will also learn how to encourage dialogue with the patient and adapt the diagnostic and treatment plan to the patient's belief system and values. This is essential for patient adherence.

Throughout this organization's inpatient and outpatient centers, more than 2,100 employees are capable of speaking and/or writing over 42 languages including American Sign Language (ASL). Should none of these employees be available, this agency has a contract with an interpretation service and can access all languages including ASL, 24 hours a day, 7 days a week.

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

As part of the routine assessment for new patients, RRP staff will strive to identify and address health care diversity issues any health care literacy barriers. These barriers may include literacy, learning disabilities, language and cultural barriers. Staff members and medical professionals will take these barriers into account as they interact with the patient and his/her family to ensure effective communication.

RRP staff members are aware of Healthy People 2020 which provides science-based, national objectives for improving the health of all Americans by encouraging collaborations across communities and sectors and empowering individuals toward making informed health decisions. These objectives include Health Literacy as an important component of health communication between patients and providers. RRP staff understand that health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health literacy includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms. Staff will assist clients in understanding and completing medical consent forms, evaluating information, analyzing relative risks and benefits, calculating dosages, interpreting test results and locating health information. To support the Health Literacy objective, RRP staff will provide health education materials at a fifth grade level or lower and will make these documents available in Spanish, Creole or the patients' native language, whenever possible.

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

Participation in the RRP is voluntary. Patients will be informed of the benefits and responsibilities of participating but will retain the final choice. The first measure of the success of this program will therefore be the enrollment rate that is achieved.

The RRP will also track (and report) the number and types of key transition services enrolled patients receive. These process measures help ensure that the program is functioning as intended.

Finally, outcome measures will demonstrate the effectiveness of this program in achieving the stated goals of reducing preventable readmissions and overutilization of emergency department services.

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

This program will receive data collection and reporting support for this program through its Information Technology (IT) Department and its Strategic Financial Support Services (SFSS) Department. With 250 employees, the IT Department implements and supports a wide variety of standardized computer applications including the newly initiated Electronic Health Record (EHR). The IT staff will create standardized reports that will run each evening to identify patients that may meet program criteria based on data obtained from the EHR. The hospital-based Care Coordinator will review these daily reports and screen patients for inclusion in the RRP.

This project will fund a part-time Data Analyst within the SCSS Department to support the project. The Data Analyst will create customized reports to assist the Care Coordinators and Transition Coaches to identify all patients who meet program criteria. The Data Analyst will also assist the Program Director and Care Coordinator in ongoing data collection and reporting as outlined in #17.

The Post Acute Support System (PASS) intervention is supported by a fully-protected, secure, and HIPAA-compliant, web-based information system, allowing for patient identification, Transition Coach documentation, medication reconciliation, information-sharing among the patients' healthcare teams, and ongoing performance measurement and program evaluation reporting.

The following measures will be monitored and reported on a quarterly and annual basis as described in **Table 8**.

Table 8 – Reporting Template

Measures	Data Sources
Care Coordination	
# of eligible patients who qualify for the RRP: # of patients identified with AMI. # of patients identified with HF. # of patients identified with PNEU. # of patients that receive health-specific education about their condition. # of patients who have been assisted in scheduling a follow up appointment. # of patients referred for follow up services at the Community Health Center.	Electronic Health Record (EHR) and RRP Customized Database
Post Acute Support System (PASS) Intervention	
<u>Process Measures</u> # patients who receive Post Discharge Nutrition Management and Meals. # patients referred to community and faith-based supportive services.	PASS Database

Intervention Effectiveness & Outcome Measures % of eligible patients that accepted the RRP: % discharge to home (including assisted living facility) % discharge to skilled nursing facility (SNF). % of patients that accepted the RRP and completed the program: % discharge to home (including assisted living facility). % discharge to SNF. 30-day readmission rate for patients that completed the RRP[2]: % discharge to home (including assisted living facility). % discharge to SNF. # of enrolled patients accessing the emergency department during the 30-day post discharge period.	

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

MRH will provide a cash match in the amount of $170,575.94 that is derived from hospital taxing district revenue. A Letter of Commitment is included as **Attachment 1.**

Budget: Please attach an excel document with your itemized budget for your project. Keep in mind that if you are awarded a project grant, your financial reporting will be compared to this budget during the project period.

MRH has included a copy of the budget as **Attachment 2**.

[2] While the goal of this program is a reduction in preventable readmissions, the measure MHS will employ ("all-cause" readmissions) is consistent with Medicare statistics.

READMISSION REDUCTION PROGRAM
AT MEMORIAL REGIONAL HOSPITAL

Hospital-Based Staffing	# FTEs	Hrs	Salary	Benefits	Total
Program Director ($50/hr)	0.03	52	$ 260	$ 52	$ 312
Care Coordinator ($34/hr)	2.00	693	$ 141,440	$ 28,288	$ 169,728
Data Analyst ($38/hr)	0.13	260	$ 4,940	$ 988	$ 5,928
Total Personnel	**2.15**	**1005**	**$ 146,640**	**$ 29,328**	**$ 175,968**
Administrative Expense (22.9%)					$ 40,296
Subtotal					**$ 216,264**

Subcontract with Independent Living Systems for the Post Acute Support Systems Model

Service	Rate	Anticipated % of Patients	# Patients for each Intervention	Average Cost Per Client
Hospital Visit with Face-to-Face Home Coaching Visit, & Telephonic Follow-up Coaching	$ 330	60%	279	$ 92,070
Hospital Visit with Telephonic Home Coaching Visit, & Telephonic Follow-up Coaching	$ 260	20%	93	$ 24,180
Hospital Visit with Face-to-Face Skilled Nursing Facility Visit(s) x 2	$ 390	20%	93	$ 36,270
Post-Discharge Nutrition Management & Meals	$ 75	30%	139	$ 10,425
Medication Transition Services	$ 65	40%	186	$ 12,090
				$ 175,035
Lead Transition Coach				$ 12,240
Total Subcontract				**$ 187,275**
TOTAL PROGRAM COST				**$ 403,539**

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL ▪ MEMORIAL REGIONAL HOSPITAL SOUTH ▪ JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST ▪ MEMORIAL HOSPITAL MIRAMAR ▪ MEMORIAL HOSPITAL PEMBROKE

July 26, 2012

Lecia M. Behenna
AHCA Medicaid Program Analysis
2727 Mahan Drive, Mail Stop 21
Tallahassee, FL 32308

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

Dear Ms. Behenna:

On behalf of the South Broward Hospital District, d/b/a Memorial Healthcare System, I am pleased to submit this ***Letter of Commitment*** for the Low Income Pool (LIP) Tier-One Milestone (STC 61) Application for the Readmission Reduction Program at Memorial Regional Hospital. Memorial Healthcare System has been a pioneer in establishing innovative programming for the uninsured, underinsured and Medicaid recipients within its 135-square mile service area and is well positioned to implement a program that will improve the transition of patients from the hospital setting to their home or other sub-acute care settings, improve the quality of care and reduce readmissions.

Memorial Healthcare System will provide $170,575.94 in match funding for this project. Since 1953, Memorial Healthcare System has served as the safety net provider for those patients that are in need of health care and lack the funding necessary to obtain care in for-profit facilities. The proposed LIP application supports Memorial Healthcare System's mission of providing quality, cost-effective, customer-focused healthcare services to patients regardless of their ability to pay, with a goal of improving the health status of the community.

Should you need additional information regarding this application please do not hesitate to contact John Benz, Senior Vice President & Chief Strategic Officer at (954) 265-3451 or jbenz@mhs.net.

Sincerely,

Frank V. Sacco, FACHE
President and Chief Executive Officer