1. **Applicant:** Pinellas County Health Department (PinCHD)

2. **Medicaid Provider Number:** 0279625

3. **Provider Type:** County Health Department (CHD)

4. **Amount Applying For:** $560,000

5. **New or Enhanced:** New

6. **Description of Delivery System and Affiliations with other health care service providers:**

The Pinellas County Health Department (PinCHD) currently provides a wide-range of medical and dental health care services to the residents of Pinellas County. Since 2008, PinCHD is a primary care medical home to thousands of uninsured, low income residents, in three locations, through a contract with Pinellas County Health and Human Services. PinCHD provides dental services for children, and for adults who meet specific criteria, in all six of its locations. PinCHD also offers core public health services for disease control and prevention, including testing and treatment for HIV/AIDS, STD's, TB, and Hepatitis, and childhood and adult immunizations. PinCHD further provides home visiting services, with a nursing component, for new families throughout the county. These services are provided in six locations, as well as in homes, the community and at school-based clinics, through appointments and walk-in clinic hours.

PinCHD fully recognizes the necessity of collaborative partnerships to better care for individuals and populations. PinCHD has a long-held reputation for partnering with large and small organizations, and for participating in innovative solutions to address current health care problems. In the service area, there are many community partnerships in place to ensure that the health care delivery system for this project is coordinated among providers.

This project will provide an increase in access to primary care services for uninsured and Medicaid recipients, and an increased focus on pre-diabetic and diabetic adults in order to reduce potentially avoidable hospitalizations and emergency room visits.

a. Delivery System

The delivery system for this project is based on the PinCHD **Medical Home model,** recognized by the National Association of County and City Health Officers (NACCHO) as a Promising Practice. This model will expand primary care capacity for uninsured and Medicaid-eligible residents through **a new community-based clinic** in two locations. The clinics will provide primary care services, and physician-led counseling about improved healthy behaviors to help reduce preventable hospitalizations and unnecessary emergency room visits. Enhancements to existing delivery systems will include an increased focus on dental care for diabetic adults, weight loss and nutritional counseling for pre-diabetics and diabetics in all PinCHD clinics, and targeted referrals to existing community resources to improve healthy behaviors for clients who are pre-diabetic, diabetic, overweight, and/or smokers.

PinCHD is a recipient of the CDC's **Communities Putting Prevention to Work** (CPPW) grant that supports a population-based approach of policy, systems and environmental changes to increase physical activity and healthy nutrition. PinCHD is also a recipient of the **Living Well** pilot grant, funded through the CDC and the Department of Health Breast and Cervical Cancer Early Detection Program, to reach women 50-64 years old who are uninsured and overweight and/or smoke. Partners in these efforts include the Health and Human Services Coordinating Council, County and City governments, Pinellas County Schools and faith-based providers. These two grants provide PinCHD with a wealth of expertise in chronic disease prevention,

community resources, and effective models for increasing physical activity and good nutrition in high-risk populations.

The PinCHD values and the design of this project have the following attributes which are known to cut costs and improve health care access. One attribute is assigning small teams to a limited number of patients, each team consisting of a doctor, a nurse, and an assistant. This is exactly how the team at the new clinic will be staffed, and similar to how the primary care teams will function with the weight management physician and nutrition counselor. Another is the PinCHD's focus on customer service. Staff receive customer service training as new employees and ongoing training each year, and there are customer service reminders posted throughout the clinics. Further, clients have the opportunity to provide feedback via electronic surveys and comment cards. Client feedback is monitored for quality assurance and used in quality improvement activities for better service, safety, effectiveness, and efficiency of care. Finally, an integrated medical and financial information system with easy access to health data is key, and the existing PinCHD electronic system provides that (see data descriptions below).

b. Affiliations with Other Health Care Service Providers

Existing Federally Qualified Health Centers: PinCHD currently partners with the two existing FQHCs in the service area, the **Board of County Commissioners** (BOCC) and **Community Health Centers of Pinellas**.

The **BOCC partnership** is based on PinCHD staffing their 330(h) grantee Mobile Medical Unit with medical providers. PinCHD also partners with the BOCC through the provision of primary care services to Pinellas County Health Program patients in three PinCHD medical homes.

Community Health Centers of Pinellas and PinCHD have worked together for more than twenty five years to meet the health care needs of the community. Community Health Centers at Largo is currently co-located within the PinCHD Largo Health Center. PinCHD and CHCP continue to partner to provide primary services to county-funded patients. Other collaboration and coordination of services include making the PinCHD volunteer specialty care network available to CHCP patients at no cost, and mammograms available to CHCP patients through the PinCHD Breast and Cervical Cancer Early Detection Program.

Other Community Providers: PinCHD coordinates with other safety-net providers of primary care services in the service area, including the **Clearwater Free Clinic, La Clinica Guadalupana, St. Petersburg Free Clinic, Turley Family Care Center**, and **Willa Carson Health and Wellness Center**. PinCHD and these providers have a long history of serving as referral resources for one another as funding and other situations change in each organization.

Community Hospitals and Health Systems: PinCHD partners with many community hospitals and health systems in the service area including Bayfront Medical Center, St. Anthony's Hospital, BayCare Health System, Florida Hospital-North Pinellas, Hospital Corporation of America (HCA), and All Children's Hospital – Johns Hopkins Health System. Collaborations include co-located staff, contracts to provide direct services to PinCHD clients, reciprocal referrals, and shared membership in advocacy and provider groups focused on health-related issues. PinCHD also works with local hospitals on their required Community Health Needs Assessment and Community Health Plan.

PinCHD works in collaboration with **Pinellas County Schools** to provide health care services to school age children through state mandated school health services, grant funded initiatives and other collaborative efforts. The PinCHD Volunteer Services program works to recruit volunteer clinical and clerical support staff for schools not funded to provide these services.

Community Health Care Collaboratives and Associations: PinCHD partners with various community health care collaborative and health care associations throughout the service area to ensure coordination of health care services in the community. One example is the **Health and Human Services Coordinating Council for Pinellas County (HHSCC).** It is their mission to develop new and more seamless health and human service delivery systems that are characterized by user friendliness, quality and productive use of resources. PinCHD and the **Pinellas County Medical Association** (PCMA) have been longstanding partners in working to improve the quality of medical care for patients and respond to the needs of the community. Further, the PinCHD Director has served as a governing board member of PCMA since 2006, bringing expertise in public health issues such as increasing access to health care.

PinCHD also participates in several health-related community coalitions, including the **St. Petersburg Chapter of the National Black Nurses' Association**, **Tobacco-Free Coalition, Tampa Bay Community Cancer Network, American Heart Association, American Stroke Association, Safe Kids, Healthy Start Coalition of Pinellas, Hispanic Outreach Center, Churches United for Healthier Congregations, Midtown Health Council, Domestic Violence Task Force,** local **Death Review Teams,** and the **Human Trafficking Task Force.** The Dental Division Director participates in the **Tampa Bay Oral Health Coalition** and the **Greater Tampa Bay Oral Health Coalition**, focused on access to care and implementation of a school based sealant program in Hillsborough and Pinellas counties. Participation in these and other coalitions help maintain the PinCHD presence in the community, provide valuable feedback about community health needs, more widely share information about PinCHD services, and assist advocacy efforts by providing health-related data.

7. **Service Area:** The service area is **Pinellas County, Florida**, a metro urban county, the sixth most populous (916,542) and most densely populated (3,291/sq. mile) in Florida, comprised of 24 municipalities (U.S. Census, 2010).

8. **Service Area characteristics (demographics, health care funding sources, etc.**):

a. Service Area Demographics (all data is from U.S. Census, 2010, and ACS 2005-2009 estimates)

Pinellas County is predominantly White (82.1%), Blacks (10.3%) are the largest minority, followed by Hispanics (8%) and Asians (3.0%). The poverty rate for the County is 11.6%. Pinellas County Health and Human Services identified five at-risk communities in the county that have 16% or more of their population living at or below 100% of the Federal Poverty Level (FPL). The low-income individuals residing within these five zones account for approximately 45% of the County's total low-income population. Enhanced services will be available to all low-income residents at PinCHD medical homes throughout the county, including the new clinic locations. These new community-based clinics will be located in at-risk zones, one in St. Petersburg/Gulfport and one in Largo. These two communities are within the highest ranked of the five at-risk zones in the county, with **25% and 27% of the population living at or below 100% FPL**, respectively.

St. Petersburg (pop: 244,769) is the county's largest city and the area of greatest need. The per capita income is $26,735, 9.7% of residents live below FPL, 27% make less than $25,000 per year and 12.8% do not have a high school diploma. The south part of the city includes six predominately Black (93%) neighborhoods where the median household income is $19,712.

Gulfport (pop. 12,029) is a small waterfront community bordering south St. Petersburg with a wide variety of residents. Gulfport includes waterfront property owners, artist collectives, and high poverty neighborhoods. Its northern and eastern neighborhoods border St. Petersburg's most

high risk neighborhoods, and its high school is located just south of this border, serving many of St. Petersburg's at risk students.

Largo (pop: 77,648), is the county's third largest city with a growing mid-county residential area of high need. Largo's Ridgecrest and South **High Point** neighborhoods are at-risk neighborhoods with disproportionate minority populations (6.3% Black, 7.3% Hispanic). The per capita income is $25,767, 7.8% of residents live below FPL, 28% make less than $25,000 per year and 13.8% do not have a high school diploma.

b. Service Area Health Indicators

Compared to Florida, Pinellas has a slightly higher % of **overweight/obese** adults (65.6 vs. 65) and a higher % of adults with **hypertension** (36.6 vs. 34.3), who have ever had a **heart attack, angina or coronary heart disease** (11.8 vs. 10.2), **stroke** (4.4 vs. 3.5), and with **diabetes** (12.4 vs. 10.4). Only 26.3% of adults consume at least 5 servings of fruits/vegetables a day, 63.2% do not get moderate physical activity and nearly 75% do not get vigorous physical activity, increasing to 81.3% in low income persons. **Tobacco use** in Pinellas is 19.3% (17.1% FL). (BRFSS 2007, 2010)

Pinellas County youth do not fare much better. Only 10% of HS students consume at least 5 servings of fruits/vegetables a day, 72% of HS students consume "junk food" at least twice per day, and 72% of HS students eat "fast food" at least once a week. Only 25.1% HS students engage in sufficient moderate physical activity and **25.9% of HS students are overweight/obese** (FL Youth Tobacco Survey, 2010). Given a recent school report, this may not improve soon. During the 2009-2010 school year, when younger students were assessed, it was found that **34.6% of 1st, 3rd, and 6th graders (combined) were overweight or obese** (BMI data from 21,921 students, School Health Services Report)

There are also significant racial and economic disparities in health indicators as shown in the table below (BRFSS, 2007):

Indicator (Adult)	Pinellas	Low Income*	White	Black
Overweight/obese	63.2%	**70%**	63.1%	**74.8%**
Hypertension	28.1%	**35.1%**	27.7%	**46.5%**
Cardiovascular Disease	12.7%	**23.2%**	5.7%	**14.8%**
Diabetes	8.7%	**15.9%**	8.0%	**19.1%**
Tobacco Use	18%	**23.3%**	17.2%	**29.1%**
Could not see a doctor in the past year due to cost	13.9%	**26.1%**	10.5%	**41%**
Uninsured	14%	**24.3%**	9.5%	**27.8%**

In addition to these medical needs, Pinellas County's low income residents do not have adequate dental care access. There are a limited number of adult dental providers for those on Medicaid, with options even more limited for the uninsured in Pinellas County. **Only 3 of the 23 dental facilities in Pinellas County accept adult Medicaid recipients**. In Pinellas County, 17.3% of all adults report being unable to see a dentist in the past year due to cost, increasing to 35% among adults with an annual income <$25,000 (BRFSS, 2007). In the past year, 70.9% of adults report visiting a dentist or a dental clinic, decreasing to 46.5% among those with an annual

income <$25,000. Similarly, 65.9% of adults report having their teeth cleaned in the past year, decreasing to 32.3% among those with a low income. Finally, **52.6% of adults reported having a permanent tooth removed because of decay of gum disease, increasing to 69.9% among those with an annual income <$25,000** (BRFSS, 2010).

c. Service Area Health Care Funding Sources

Twenty-six percent (143,625) of adults 18-64 in Pinellas County are uninsured, which rises to 42% of Black adults and 52.9% of Hispanic adults (U.S. Census Bureau, 2010). The county's primary care medical homes, including PinCHD clinics, served 15,700 uninsured, low income adults in fiscal year 2011, a fraction of the uninsured population. The Board of County Commissioners is currently investigating how to double that number, and this project is a well-timed supplement to their efforts.

Nearly 18% of residents in Pinellas County rely on Medicaid for their health care coverage. This increases to 46% in the five high-poverty zones, 51% of whom are children (University of South Florida, Policy and Services Research Data Center).

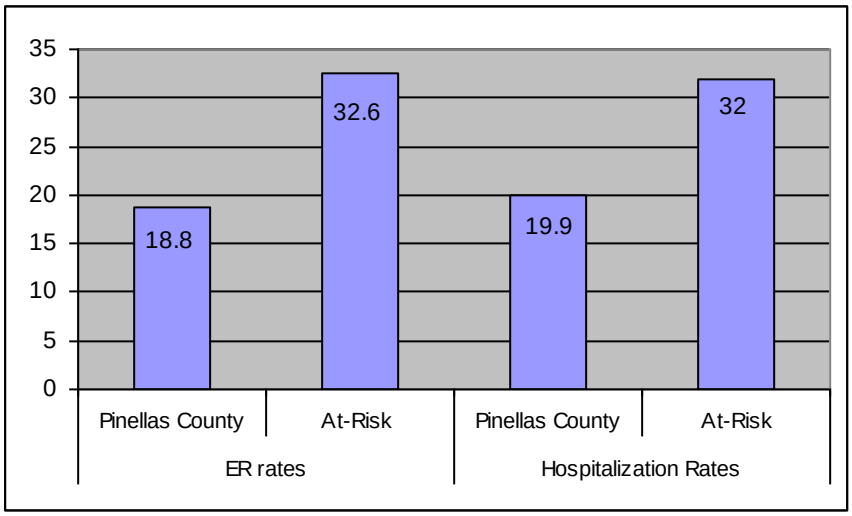
With these high rates of both uninsured and Medicaid-eligible residents, especially among those living in poverty, the costs of emergency room visits and hospitalizations continue to be a financial and social burden. According to the CDC, Medicaid beneficiaries under the age of 65 showed the most emergency room utilization. Further, while the uninsured were no more likely to use the emergency room than those with private insurance, those uninsured who are also living in poverty were nearly twice as likely to use the emergency room as those living above 400% FPL (CDC, National Center for Health Statistics, 2007).

The tables below offer a snapshot of the costs and utilization of emergency rooms (ER) and hospitals in Pinellas County in recent years (FloridaHealthFinder.gov, 2011).

ER Visits and Hospitalizations at Pinellas County Hospitals (10/1/2010 – 9/30/2011)
(*Uninsured refers to self-pay and those receiving other local/state assistance)

	ER Visits (%)	ER Costs (%)	Avg Cost per Visit		Hospital Admissions (%)	Admission Costs	Avg Cost per Visit
All Payer Types	289,811	$1,153,978,781	$3,982		147,446	$6,718,942,619	$45,569
Medicaid and Kidcare Only	82,756 (29%)	$244,012,030 (21%)	$2,949		27,995 (19%)	$1,099,673,515 (16%)	$39,281
Uninsured Only*	68,977 (24%)	$238,143,552 (21%)	$3,453		9,187 (6%)	$337,993,685 (5%)	$36,790

Average Rates (per 10,000) of ER Visits and Hospitalizations Due to Diabetes, 2008 – 2010
("At-Risk" refers to the five high poverty zones in the county)



9. **Organizational Chart and Point of Contact:** Point of Contact is Wendy Loomas, wendy_loomas@doh.state.fl.us or 727-824-6979 (p) and 727-820-4292 (f). The organizational chart is attached as **Appendix A**, and shows where the LIP Project will fit within the organization. There will be a LIP Coordinator who will coordinate all project activities, be responsible for reporting, and directly supervise the clinic team. The LIP Coordinator will report to the Medical Services Director.

10. **Proposed Budget:** A detailed lined budget, in Excel, is attached under separate cover as **Appendix B**. It reflects a fiscally conservative and clinically proactive approach to providing additional access to care for the service area as described above. The budget calculations are based on historical financial and operational data. PinCHD requests the amount of $560,000 be granted for year one. Since this proposal utilizes existing centers there are no anticipated one-time capital costs included. The state required match totals $236,712.

11. **Project Summary:**

    This project provides PinCHD with the opportunity to provide better care for individuals and better health for populations by increasing the number of sites where primary care is provided and enhancing existing primary care services to address poor nutrition, physical inactivity, and limited access to dental care. Since 2008, the Pinellas County Health Department (PinCHD) is a primary care medical home to thousands of uninsured, low income residents, in three locations, through a contract with the Pinellas County Health and Human Services Department. This program will be referred to herein as county primary care.

    PinCHD takes seriously its public health role of ensuring a health care safety net for its residents. As such, PinCHD is known as a leader in creating innovative programs and seeking new funds that help to bridge the gaps for those who do not qualify for, or who lack access to, existing healthcare programs.

    To provide better care for individuals, this proposal includes an expansion of primary care dental and medical services in existing PinCHD sites, as well as expansion of the infrastructure and service hours for primary care at two new sites. To provide better health for the population and reduce unnecessary emergency room visits and avoidable hospitalizations for ambulatory care sensitive

conditions, this proposal includes an expansion of weight loss and nutrition counseling services and referrals for those primary care and other clients identified as diabetic or pre-diabetic.

a. Better Care for Individuals

1. There will be two **new community-based clinic** locations added through this project, for 40 hours per week. These hours are expected to accommodate 1,600 clients for 4,750 visits, assuming a start-up period and maximum capacity of 3 adults/hour and 4 children/hour on average. Clients seen in these clinics will be referred to as "LIP clients."

    a. The first location will be at the new PinCHD mid-county center in **Largo, near the high-poverty zone of High Point** described above (8.a). This location does not currently offer adult primary care, so this will be the first medical home in this area provided by the PinCHD. The clinic hours will be 11:30am-6:00pm on Mondays and Fridays, 12:30pm-7pm on Wednesdays, and 8:30-11:30am on Tuesdays and Thursdays. It will be staffed by an examiner, a nurse, and a clerical support person. This team will be supported on-site by the infrastructure of PinCHD that includes IT, Admitting, and Medical Records. Eligible residents will be those who live in Pinellas County, are uninsured and live between 100-200% FPL, or receive Medicaid. This clinic will be open to children and adults, and it will offer primary care services with referrals to volunteer specialists through the existing PinCHD provider network.

    b. The second new location will be at **Boca Ciega High School**, which serves Gulfport and south St. Petersburg. PinCHD currently operates a full-service clinic for students at this location during school hours. This project will add clinic hours after school from 2:30pm – 5:30pm Tuesdays and Thursdays for any low income, uninsured children and children who receive Medicaid, regardless of their age or school. This school borders the west central part of St. Petersburg's high-poverty zone and is a section of the county that has no other primary care clinic for uninsured or low income residents. The staff will be the same team described above.

2. The expansion of primary care **dental services** will be accomplished through increasing hours to accommodate new adult LIP clients and increasing appointments for diabetic county primary care clients. New adult LIP clients, as described above, will be provided access to dental care through expanded clinic hours two evenings each week (5pm-8pm) and one Saturday each month (open 9am-4pm, 1 hour lunch). This component has a maximum capacity to serve a minimum of 500 unduplicated clients through 2,500 encounters.

    PinCHD pediatric dental clinics have traditionally had a "no show" rate of 15-20%, and the St. Petersburg clinic has consistently been at 20%. Due to the proximity of the dental clinic to the primary care clinics, adult clients can easily be seen in both clinics in one day. With this project's focus on preventing ER visits and hospitalizations, current county primary care clients who are diabetic and in need of dental care will be referred to the dental clinic by their primary care provider. This will reduce the per capita cost of dental care by more fully utilizing existing staff, and will provide better care for individuals who are diabetic. On average, each client will receive 5 visits, 2 with the hygienist and 3 with the dentist, averaging 4.5 hours total per client over several months. This component is expected to serve a minimum of 240 unduplicated clients through 1,200 encounters at 5 locations countywide.

3. The expansion of primary care medical services will include **one-on-one weight management** conducted by a PinCHD physician. This physician is Board certified by the American Board of Bariatric Medicine, and worked in a private Bariatric practice for three years before joining the PinCHD staff. With this expertise, this physician recently completed

a 14-month pilot of these services in two PinCHD sites. During that period, 173 county primary care clients lost 735 pounds collectively, with some just beginning, many losing 10-15 pounds each, and one client having lost over 50 pounds. This project will add these clinics in the St. Petersburg center and the Mid-County/Largo LIP clinic. The clients in this component are county primary care and LIP adult clients who are overweight or obese, and already enrolled for primary care services. The physician's hours will be increased from 15 to 25 per week, through this project, which is expected to yield 20 more visits per week. This component is expected to reach 100 unduplicated new clients who will be seen multiple times during the project year.

b. Better Health for Populations

4. PinCHD has consistently cared for approximately 830 diabetics among the county primary care clients every year. Based on national statistics, it is estimated that there are three times that many clients who are pre-diabetic and only 10% of them know it. As described above, diabetics in Pinellas' high-poverty zones visit the ER and are hospitalized at a significantly higher rate than other diabetics. If diabetics have their disease under control, and pre-diabetics reduce their risk or delay the onset of diabetes, these hospital visits can be reduced. In fact, the NIH and CDC recently concluded that if a pre-diabetic person loses 5-7% of their body weight and gets at least 150 minutes of moderate physical activity per week, they can reduce their risk of developing type 2 diabetes by 58%. To improve the health of these populations, this project is going to focus on assisting diabetics and pre-diabetics with weight loss through physical activity and nutrition.

   The **Living Well** project, described above (6.a), is a promising pilot for reaching clients with referrals to existing community resources. An important Living Well finding was that Pinellas County is rich in low and no cost physical activity and nutrition services and opportunities. Staff also found that many clients did not know about these. Living Well staff contacted clients by phone, conducted a survey to determine their willingness to make healthy changes, and then sent each participant an informational packet customized to that person's neighborhood and needs. Of the 100 clients surveyed during the pilot phase, 72 indicated a willingness to work on their weight and 15 indicated a willingness to quit smoking. At the time of the first follow-up, 27 (37.5%) in the first group had begun a weight management program and 9 (60%) in the second group had started a smoking cessation program.

   This Living Well component will adapt the above model to a clinic setting with the goal of motivating overweight clients, especially diabetics and pre-diabetics, to increase their physical activity and improve their nutrition. A full-time Health Educator will be hired to work with clients one-on-one after the client has received community referrals from a PinCHD clinician. For some clients, one or two follow-up phone calls will be sufficient, and other clients will need more motivation and attention. The Health Educator will make phone calls, appointments in person, and see clients when they are on site for other visits. The Health Educator will focus in St. Petersburg because it is the busiest center with the most at-risk clients. The existing PinCHD primary care nutritionist can assist with clients in other centers at no cost to the project.

   During the initial project period, the LIP Coordinator will work with the Living Well staff, the weight management clinician, and the primary care nutritionist to determine the most effective method and materials for this intervention. Subsequently, all PinCHD clinical staff will be trained to counsel overweight clients, and make customized referrals to either community resources, the weight management physician, the Living Well staff, or a combination thereof. These referrals will be tracked in the electronic medical record, as will

the clients' actions taken and improvements made on subsequent visits. The Health Educator is expected to see 2,200 unduplicated clients in 2,400 visits.

c. Reducing Per-Capita Costs: As mentioned above, this project will help reduce per capita costs for PinCHD by increasing client access to the dental services through increased efficiency, without increasing staffing. It will further impact costs overall by increasing access to primary care through its new community-based clinic in two locations where there is no easy access to primary care currently. Finally, it is expected to increase cost effective care by providing a medical home setting for those who might otherwise utilize an emergency room.

12. Plan for identifying participants to be served in the project:

To identify diabetic and pre-diabetic clients for the components below, this project will utilize the criteria established by the American Diabetes Association and CDC National Diabetes Prevention Program. PinCHD utilizes the Department of Health (DOH) Health Management System (HMS) as its electronic health record (details below) which allows easy access to a client's BMI, diagnoses, and blood test results that indicate diabetes or pre-diabetes.

a. Better Care for Individuals

1. **Community-Based Clinics**

a. Mid-County/Largo Clinic: Participants in this component will be Pinellas residents, uninsured, living at 100%-200% FPL, or will be Medicaid recipients. When enrolling, they will be screened for eligibility for county primary care or Medicaid for increased assistance.

b. **Boca Ciega Clinic**: Participants in this component will be children (under 18), and uninsured or Medicaid recipients. These children will also be screened for eligibility for Medicaid and Kid Care.

2. Dental: Participants in this component will be diabetic county primary care clients and any LIP clients who are in need of dental care. They will be identified by their primary care provider and referred to the dental clinic at the time of their primary care visit. Clients will be seen or receive an appointment that day by the Dental Clinic.

3. Weight Management Clinic: Participants in this component will be county primary care or LIP clients with a BMI of 25 or above, with priority to those who are also diagnosed with diabetes or pre-diabetes. They will be referred by their primary care provider for an initial appointment with the weight management clinic, and future primary care appointments will be coordinated with the Weight Management Clinic appointments whenever possible.

b. Better Health for Populations

4. Living Well – Referrals to Community Resources: This component will first involve training clinicians who work with adult clients who come for primary care, family planning, STD, triage and/or LIP services. The participants will be their clients who have a BMI of 25 or above, who are diabetic or pre-diabetic, who have poor nutrition, or a combination of those risk factors. BMI, nutritional habits, and pre-diabetes/diabetes diagnoses and test results are available in HMS.

Living Well – Health Educator: Participants in this component will be those clients referred from the clinicians when it is determined that a client needs personalized attention to help motivate an increase in healthy behaviors. The Health Educator can see the client at the time of the other visit, if convenient, or offer telephone support and/or a future appointment. This educator will also work to create a supportive environment for positive behaviors through

increasing the visibility of community resources and positive messages throughout PinCHD clinics.

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

As described above, over one-fourth of Pinellas County adults 18-64 are uninsured, and about half of Pinellas' Black and Hispanic adults are uninsured. A study by the Kaiser Commission on Medicaid and the Uninsured showed that more than 40% of uninsured persons (9% insured) reported postponing or forgoing needed health care because they did not have a regular place to receive care.

Access to health care for all residents, especially uninsured residents, is key to better care for individuals and better health for the population. Unfortunately, Pinellas County contains **five Medically Underserved Population** (MUPs) and **six designated Health Professional Shortage Areas** (HPSAs). The MUPs and HPSAs within Pinellas County can be seen in the tables that follow. Note that both areas in which this project will add clinic hours are listed in both tables.

Medically Underserved Populations (MUPs) in Pinellas County

Population Group	ID#	Type	Score
Low Income - St. Petersburg	**05047**	**MUP**	**61.10**
Low Income - Tarpon Springs	07400	MUP	57.80
Low Income - Bayview	07404	MUP	53.20
Low Income - Central Clearwater	07122	MUP	53.20
Low Income - Largo	**07407**	**MUP**	**52.90**

Health Professional Shortage Areas (HPSAs) in Pinellas County

Population Group	ID#	FTEs	# FTEs Short	Score
Primary Medical Care				
Low Income - St. Petersburg	**1129991236**	**6**	**9**	**16**
Low Income - Largo	**112999126H**	**4**	**4**	**14**
Low Income - Tarpon Springs	112999126F	1	0	13
Low Income - Bayview	112999126G	0	4	13
Low Income- Pinellas Park	112999125Z	1	5	12
Low Income - Central Clearwater	112999121B	5	0	3
Dental				
Low Income - St. Petersburg	**612999125E**	**3**	**8**	**17**
Low Income - Tarpon Springs	612999125F	0	1	13
Low Income - Bayview	612999125H	0	3	12
Low Income - Largo	**612999125C**	**2**	**4**	**10**
Low Income- Pinellas Park	612999125B	2	3	8
Low Income - Clearwater	612999125G	3	1	4

This project will provide access to primary care services in two geographic areas to two population groups not currently served by PinCHD. The high school clinic where uninsured minors will be offered primary care services is centrally located within the boundaries of the lowest income section of St. Petersburg and Gulfport. The new primary care clinic site in Mid-County/Largo for uninsured adults is located 3.5 miles from the center of the high-risk High Point area in Largo. For some residents who rely on the bus, this will cut down on the previous average of 45-90 minutes to reach a PinCHD site.

In addition to increased primary care access at the new sites, this project will enhance primary care at existing sites through an increase in dental services, weight loss and nutrition counseling, and targeted referrals for pre-diabetic and diabetic clients. These services, focused on this population, are intended to reduce potentially avoidable emergency room visits and hospitalizations, as well as decrease health care costs for these clients overall.

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

The enhancement includes **increased hours of operation** in the evenings at two new primary care sites, as well as evenings and Saturdays at dental clinics. The after school community clinic that serves St. Petersburg and Gulfport will be open Tuesdays and Thursdays from 2:30-5:30pm, the new clinic in Mid-County/Largo will be open late three weekdays, from 11:30am-6pm on Mondays and Fridays, and from 12:30pm-7pm on Wednesdays. The St. Petersburg PinCHD dental clinic will also add evening and Saturday hours by staying open until 8pm twice a week, and opening for 6 hours one Saturday per month.

15. Capability to serve minority and culturally diverse populations is as follows:

Often sought by community partners as **lead agency for collaborative grants**, PinCHD has agreements and contracts with virtually all social and health care organizations in the County, and addresses minority health disparities in the following areas. **Maternal and Infant Mortality through CREED** (Communities Creating Racial Equality and Ending Racial Disparity), a community-based consortium dedicated to reducing Black infant mortality which includes community members and professionals who live and/or work in the service area. **HIV/AIDS** prevention, education, testing and counseling services provided to hard-to-reach minority populations through PinCHD collaborations with minority organizations. **Diabetes education and health screenings** offered by Lifeline Services Inc. and Diabetes Charitable Services in minority communities through PinCHD referrals. The PinCHD **Childhood Immunizations Outreach Team** targets hard-to-reach populations under the auspices of a countywide Immunization Task Force, which includes the Black Nurses Association. **Cancer:** PinCHD currently manages the **Breast and Cervical Cancer Screening Program,** servicing low income, uninsured populations. Other efforts include a partnership with **Moffitt Cancer Center and Research Institute/Tampa Bay Community Cancer Network, a National Cancer Institute** funded grant involved with creating and implementing community based interventions to impact cancer disparities. During the upcoming renovations of the Clearwater CHD, the **Hispanic Outreach Center** is providing space for clinicians to operate limited triage and WIC services for clients who are comfortable in that setting and cannot make it to another PinCHD location during this time. These current activities show that PinCHD is well-accepted and successful in the community at large and in the service area specifically.

16. Health care diversity issues and literacy barriers will be identified and addressed as follows:

Ensuring **better health outcomes for vulnerable populations** is the job of PinCHD Office of Health Equity. The Health Equity Officer takes an active role in ensuring staff is assessing and developing

their cultural competence and linguistics in order to consider all factors that contribute to patient health outcomes. Staff members are also encouraged to understand how social determinants such as education level, socio economic factors, environments, and a lack of comprehension of the English language can impact healthcare accessibility. Cultural considerations that can affect a patient's health literacy are also taken into account.

The **Office of Health Equity** collaborates and partners with numerous community organizations as a means of addressing the holistic health of vulnerable populations. Through these partnerships, PinCHD is involved in community based research, environmental policies, and health education projects designed to address health equity.

In addition, PinCHD has a **Health Equity Team** with representatives located in each of its 6 centers. Team members are responsible for ensuring that the agency meets the *"cultural and linguistic needs of the growing and diverse clientele of the Pinellas County Health Department and aids in the adherence to Federal mandates and guidelines of CLAS."* The Office of Health Equity and the Health Equity Team will include the LIP Project in its oversight.

Ensuring **Health Literacy** for PinCHD clients is the job of all staff under the direction of the PinCHD Office of Health Equity and the agency's **Public Information Officer** (PIO). All patient materials such as flyers and newsletters are submitted to the PIO for approval before using them. The PIO runs the text through the language tools in Microsoft Office (Flesch-Kincaid Reading Level and Flesch Reading Ease) to ensure that they are not written above the sixth-grade reading level that is assumed to be the average degree of literacy for many Americans. Whenever possible, text is combined with graphics to show rather than tell. The staff is directed to use the *English-Spanish Dictionary of Health Related Terms*, a publication from California's Office of Binational Border Health which uses health terminology commonly understood in the Mexican population to describe their health concerns.

The agency has also provided medical translation training to many of its bilingual staff, and maintains a list of available translators on its internal web site for easy access to all employees. As part of the Florida Department of Health, PinCHD complies with the Governor's 2007 Executive Order mandating "plain language," which is defined as "clear language that is commonly used by the intended audience."

17. Measures and data sources to evaluate the effectiveness of each initiative in the project:

a. Better Care for Individuals

1. **Community-based clinics** (Mid-County/Largo PinCHD and Boca Ciega HS): This component is designed to address the LIP goals to reduce potentially avoidable hospitalizations and emergency room visits, expand the primary care infrastructure, provide expanded service hours, add an examiner in an area with limited access, and provide better care for individuals. To measure the success of this component, PinCHD will report the following:

Measure	Data (Source)	Effectiveness Measure
Clinic visits per quarter	# visits (HMS)	Average 1,187 per quarter
New applicants for Medicaid or the county primary care	# applications (manual count)	Average 48 per quarter
Clients reporting ER diversion	# clients reporting less ER use (HMS)	Average 48 per quarter

Excellent customer service	Comment cards (manual) and touch screen	Overall satisfaction of 90% or higher each quarter (DOH standard)

2. Dental: This component is designed to address the LIP goals to expand the primary dental care infrastructure, provide expanded service hours, increase access to dental care, and reduce per capita costs. To measure the success of this component, PinCHD will report the following:

Measure	Data (Source)	Effectiveness Measure
Percent of slots filled	Clinic Schedule (HMS)	At least 85% of slots filled, on average, each quarter at each site
Diabetic county primary care clients seen	# county primary care clients with Diabetes diagnosis seen by Dental (HMS)	300 visits per quarter
LIP clients seen	# LIP clients seen after hours (HMS)	625 visits per quarter
Excellent customer service	Comment cards (manual) and touch screen	Overall satisfaction of 90% or higher each quarter (DOH standard)

3. Weight Management Clinic: This component is designed to address the LIP goals to reduce potentially avoidable hospitalizations and emergency room visits, expand the primary care infrastructure, provide expanded service hours, better care for individuals, and better health for populations. To measure the success of this component, PinCHD will report the following:

Measure	Data (Source)	Effectiveness Measure
Referrals	# clients seen by physician (HMS)	Average of 25 new clients per quarter
Weight Loss	# pounds lost by clients in program (HMS)	At least 75% of the clients will lose 5-7% of their body weight within an appropriate amount of time, based on starting weight
Excellent customer service	Comment cards (manual) and touch screen	Overall satisfaction of 90% or higher each quarter (DOH standard)

b. Better Health for Populations

4. Living Well - Referrals to Community Resources: This component is designed to address the LIP goals to reduce potentially avoidable hospitalizations and emergency room visits, and

provide better health for populations. To measure the success of this component, PinCHD will report the following:

Measure	Data (Source)	Effectiveness Measure
Develop model based on Living Well	Curriculum and materials	Model, curriculum and materials will be ready for training clinicians by month 3 of the grant year
Training of clinicians	Sign-in sheets	80% of clinicians attend training
Referrals made	# referrals (HMS)	90% of trained clinicians make at least 10 referrals to community resources, weight management clinic, or nutritionist per month
Excellent customer service	Comment cards (manual) and touch screen	Overall satisfaction of 90% or higher each quarter (DOH standard)

4. Living Well – Health Educator: This component is designed to address the LIP goals to reduce potentially avoidable hospitalizations and emergency room visits, expand the primary care infrastructure, provide better care for individuals, and better health for populations. To measure the success of this component, PinCHD will report the following:

Measure	Data (Source)	Effectiveness Measure
Referrals	# visits (HMS)	600 visits per quarter
Excellent customer service	Comment cards (manual) and touch screen	Overall satisfaction of 90% or higher each quarter (DOH standard)

c. Reducing Per-Capita Costs. This project will help reduce per capita costs for PinCHD by increasing client access to the dental services and nutritional counseling without increasing staffing. It will further impact costs overall by increasing access to primary care through its new community-based clinic in two locations where there is no easy access to primary care currently. Finally, it is expected to increase cost effective care by providing a medical home setting for those who might otherwise utilize an emergency room. To measure the success of this component, PinCHD will report the following:

Measure	Data (Source)	Effectiveness Measure
Decrease in "no shows" (Dental Clinics)	# no shows (HMS)	Decreases by 50% during the grant period
Increase in primary care access	# visits (HMS)	Average 80 per week during reporting period
Decrease in ER use by uninsured residents	# clients reporting less ER use (HMS)	Average 48 per quarter

18. Data collection and reporting capabilities, including systems and staffing resources and a reporting template are as follows:

Data collection and reporting capabilities are provided by the DOH Health Management System (HMS) which functions as the electronic health record with clinical encounter information entered real-time as the patient is seen. Encounter services, CPT codes, diagnosis codes, vitals and measures, medical histories, progress notes, orders and referrals are entered at the time of the visit and information is immediately available in HMS to any PinCHD staff granted appropriate access. Reports are available for follow-up on the status of any referral. The system offers care plan templates for chronic diseases allowing providers to load the standard of care protocols for specific diseases and enter both provided and planned services for individual patients. Case managers have electronic access to progress notes, results, orders and diagnosis information charted by PinCHD providers and volunteer specialists. Reports are used to monitor both planned and provided services and referrals entered into the care coordination module. Service reports can be run with a wide range of selection criteria, including specific patients, date ranges, service sites, provided or planned services, service providers and more.

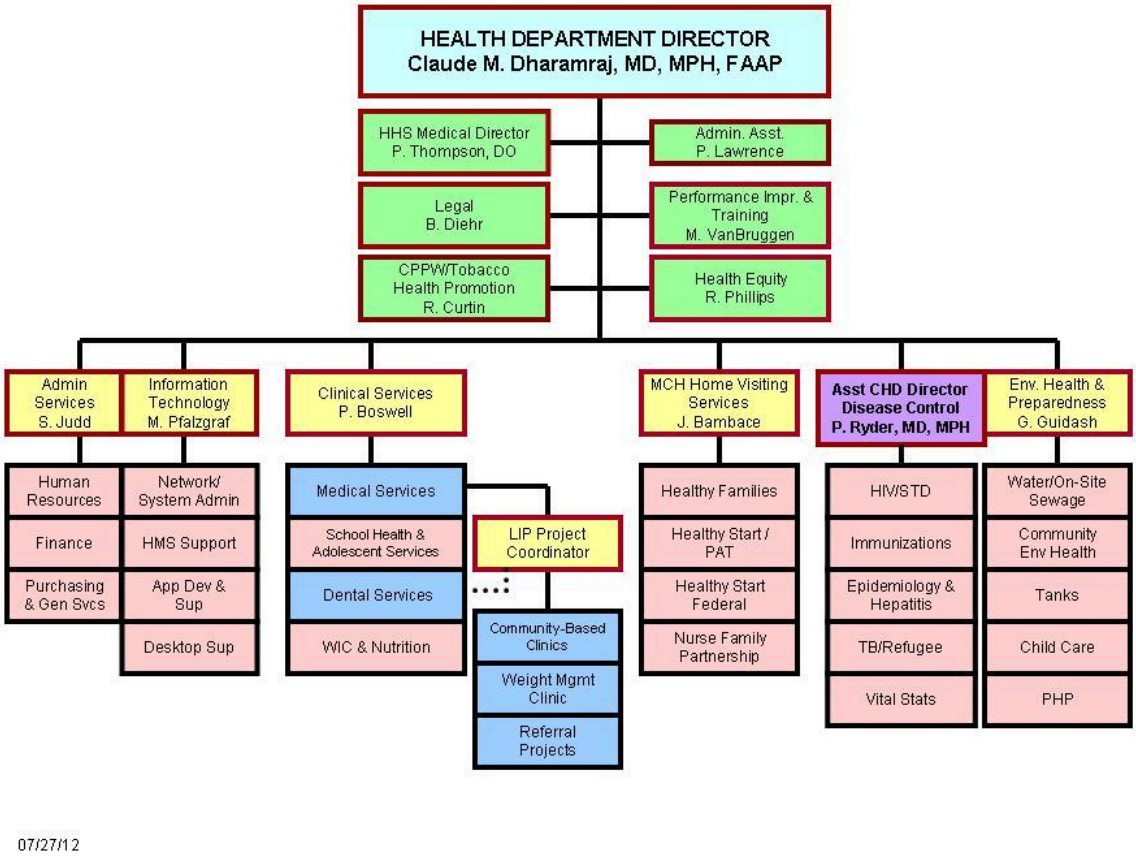
This project will utilize HMS to schedule patients, manage their care, share information between internal providers, and make appropriate internal and external referrals.

The reporting template is attached as **Appendix C**. Each measure described above, by component, is listed in this template, including an overall measure of Excellent Customer Service. The column labeled "Comments" would be used for any corrective actions or explanations for missed or exceeded goals.

19. Letter of commitment from the local match fund source:

A letter of commitment from PinCHD is attached as **Appendix D**. Total cost of the proposal is $513,000 (see detailed budget Appendix B), the state match of 42.27% is calculated as $216,845.

Appendix A – Organizational Chart



NOTE: Appendix B – Budget is sent under separate cover as an Excel spreadsheet

Appendix C – Reporting Template (proposed)

MEASURE	DATA	GOAL	Δ	COMMENTS
Component 1 – LIP Clinics				
Clinic visits per week				
New applicants for Medicaid or the county health program				
Clients reporting ER diversion				
Component 2 – Dental Clinics				
Percent of slots filled				
Diabetic county primary care clients seen				
LIP clients seen				
Component 3 – Weight Mgmt Clinics				
Referrals				
Weight Loss				
Component 4 – Living Well				
Develop model based on Living Well				
Training of clinicians				
Referrals (community)				
All Components				
Excellent customer service				
Cost Reductions				
Decrease in empty ‘slots’ (Dental Clinics)				
Increase in nutrition counseling				
Increase in primary care access				

Appendix D – Commitment Letter

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.

Pinellas County Health Department is submitting a request for $560,000 to expand access to health care services for the uninsured. The Department will meet this obligation by providing the required match amount of $236,712 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

Division of Public Health Statistics and Performance Management
4052 Bald Cypress Way, Bin A05 • Tallahassee, Florida 32399-1701
Phone: (850) 245-4009 • Fax: (850) 921-1898 • https://www.floridashealth.com

Appendix B

Pinellas County Health Department

Low Income Pool Project Application Budget Narrative

12 Month Budget 2012-2013

Budget Summary by Goals			
Better Care for Individuals	**Goals**		
Community Based Clinics	1	2 new locations, Largo & Boca Ciega HS	$ 322,384
Dental	2	Expansion of existing services	$ 105,761
Weight Management	3	Expansion of existing services	$ 33,241
Better Health for Population			
Living Well	4	Referral to community resources & dietician	$ 37,080
Total Program Expenses			**$ 498,466**

Expenditure Line Item and Explanation				**Amount**
Salaries				
Classification	**Goals**	**FTE**		
Asst. Comm. Hlth. Nursing Director	**all**	0.25	Coordination & Oversight of LIP project	$ 15,115
Community Health Nursing Supv.	1	1.00		$ 42,991
Family Support Worker	1	1.00		$ 26,438
Dental Assistant	2	3.00	$19.22/hr overtime 348 hrs * 3 staff	$ 20,066
Dental Hygienist	2	1.00	$43.01/hr overtime 348 hrs * 3 staff	$ 14,967
Total Salaries		**6.00**		**$ 119,577**
Other Personal Services (OPS)				
Classification		**FTE**	**hours & rate**	
Physician - Community Based Clinics	1	1.00	40 hrs* 48 wks = 1920 hrs @ $65.00/hr	$ 124,800
Dentist	2	0.17	6 hrs * 10 months= 348 hrs@$50/hr	$ 17,400
Physician - Weight Management	3	0.17	10 hrs /wk 35 wks @ $78.13/hr	$ 27,346
Health Educator - Living Well project	4	1.00	40 hrs*48 weeks= 1920 hrs @ $13.43/hr	$ 25,786
Total Other Personal Services		**2.34**		**$ 195,331**
Fringe Benefits				
Fringe benefits are computed as a percentage of salaries and includes FICA (7.65%), retirement (5.18%), & health and life insurance(average of 36%) for career service positions. OPS positions have only include fringe (1.45%).				
Fringe	1		48.83% (1.45% for OPS)	$ 39,402
Fringe	2		48.83% (1.45% for OPS)	$ 18,097
Fringe	3		48.83% (1.45% for OPS)	$ 1,873
Fringe	4		48.83% (1.45% for OPS)	$ 1,850
Total Fringe Benefits				**$ 61,222**
Contractual Services	**Area**		**Description**	
Lab Corp.	1		Laboratory services $52.50/client/yr, $15/visit	$ 59,588
School Board of Pinellas County	1		Customer Support at school based clinic $25.50/hr	$ 4,600
Copy machine lease (15% of cost)	1		$216/month * 12 months *15% at school clinc	$ 389
Total Contractual Services				**$ 64,576**
Operating Expense	**Area**		**Description**	
Office/operating supplies	1		Paper, toner, folders, labels, forms etc.	$ 1,500
Medical supplies	1		Syringes, table paper, gowns, etc.	$ 6,100
Travel expense @ $0.445/mile	1		travel between the 2 clincs, meetings, training, etc.	$ 1,922
Telephone & fax service	1		$35/month * 12 months (school clinic)	$ 420

Expenditure Line Item and Explanation			Amount
Operating Expense (cont.)	**Area**	**Description**	
Internet connection at School Clinic	1	$207/month * 12 months (school clinic)	$ 2,484
Cell phones	1	$20/month * 2 FTE	$ 480
Janitorial service	1	$1.67 per sq. ft. * 750 sq. ft. (Largo clinic)	$ 1,253
Utilities	1	$3.28 per sq. ft. * 750 sq. ft.(Largo clinic)	$ 2,460
Dental & office Supplies	2	$13/ encounter average	$ 33,719
Educational Materials	3	Educational Brochures and pamphets	$ 1,000
Educational Materials	4	Educational Brochures and pamphets	$ 5,420
Office/Operating supplies	4	folders,labels, pens, printer etc …….	$ 1,000
Total Operating Expenses			**$ 57,758**
Direct Program Expenses			
Salaries			$ 119,577
Other Personnel Services			$ 195,331
Fringe Benefits			$ 61,222
Total Salaries & Fringe Benefits			**$ 376,130**
Total Contractual Services			$ 64,576
Total Operating Expenses			$ 57,758
Administrative Cost			
Administrative costs are computed as a percentage of direct salaries and wages including fringe benefits.			
The Department of Health's approved rate agreement provides for a maximum Health Services rate of 25%.			
The county health department has elected to recover 16.36%, due to funding restraints.			
Total Administrative Cost		Based on 16.36% of Salary and Fringe	$ 61,535
Total Program Expenses			**$ 560,000**

Total LIP Funding	**$**	**323,288**
Total State Match: 42.27% of total award	**$**	**236,712**
Total Program Revenue		**$ 560,000**