



Legislative Request
Pilot Healthcare Reform Initiative

Health Intervention with Targeted
Services (HITS) Program

January 2008

Background

- Health Intervention with Targeted Services (HITS). The HITS Program is a collaborative program designed to improve healthcare and provide a long-term solution to address the needs of the uninsured/underinsured, resulting in a reduction of uncompensated care costs for the taxpayers and MHS. This program targets low income neighborhoods and locations are chosen based on the highest concentrations of uninsured/underinsured residents within zip codes that have received services at MHS in South Broward County.
- The program has 3 major goals:
 - To improve the health status of our community by linking the uninsured and underinsured to a “medical home”.
 - To maximize the use of community, state, and federal resources.
 - To reduce uncompensated care costs, preventable hospital admissions and avoidable emergency room visits.
- Based on 2005 inpatient data on uncompensated care in southern Broward county, we identified those areas generating more than \$44 million of the \$129 million charity and bad debt “write-offs”. These high levels of uncompensated care place a severe burden on the tax payers and MHS. We then determined that many residents in these areas may have qualified for government-sponsored programs such as Medicare and Medicaid or may have been eligible to establish a medical home at one of the primary care centers operated collaboratively by Broward County, Department of Health and MHS.
- After reviewing the results of this program, we believe the HITS program and outreach to all areas of south Broward County, is necessary. This program, over time, improves the health status of south Broward residents by providing a medical home and by placing individuals with chronic disease conditions into a disease management program. Because of this, we will reduce avoidable emergency room visits and preventable admissions in the future.

Health Intervention with Targeted Services (HITS) Program

Phase	Interventions	Reporting
Phase I Overall Program (Approximately 7,000 individuals per year)	<ul style="list-style-type: none"> ■ Home Visitation ■ Health Screening ■ Medical Home Referral ■ Eligibility Outreach ■ Health Education ■ Nurse Triage Services 	<ul style="list-style-type: none"> ■ Activity Analysis ■ Health Status Reports ■ Eligibility Report ■ Longitudinal Study <ul style="list-style-type: none"> ■ Health / Financial
Phase II Preventable Admissions (Approximately 1,000 individuals per year)	<ul style="list-style-type: none"> ■ Home Intervention <ul style="list-style-type: none"> ■ Disease Management ■ Health Education ■ Medical Home Referral ■ Eligibility Outreach ■ Nurse Triage Services 	<ul style="list-style-type: none"> ■ Activity Analysis ■ Health Status Reports <ul style="list-style-type: none"> ■ Case Mgt. Reports ■ Eligibility Report ■ Longitudinal Study <ul style="list-style-type: none"> ■ Health / Financial
Phase III Avoidable Emergency Services (Approximately 2,000 individuals per year)	<ul style="list-style-type: none"> ■ Home Intervention <ul style="list-style-type: none"> ■ Frequent Flyers ■ Health Education ■ Medical Home Referral ■ Eligibility Outreach ■ Nurse Triage Services 	<ul style="list-style-type: none"> ■ Activity Analysis ■ Eligibility Report ■ Longitudinal Study <ul style="list-style-type: none"> ■ Health / Financial



Health Intervention with Targeted Services (HITS) Program Outcome Reporting – First Two Pilot Programs

■ Demographics

- 673 households
- 1,709 individuals
- 98.6% no primary care physician
- 59.6% no insurance
- MHS Eligibility Outreach effort results
 - Qualified 121 for Medicaid
 - Qualified 197 for MHS Primary Care System
 - 209 still In qualifying progress
- Conclusion
 - Increased # with Medical Home
 - Maximized eligibility / revenues
 - Reduced impact of uncompensated care on MHS

■ Health Statistics

- 125 physicals performed
- Screened
 - 401 blood pressure
 - 379 cholesterol
 - 63 immunizations
 - 41 Accuchecks
- Observations
 - 39% high blood pressure
 - 42% high cholesterol
 - 53% of known diabetics had abnormal results
- Conclusion
 - Increased health awareness
 - Increased access to services
 - Increased health status
 - Possible prevention of costly admission



Health Intervention with Targeted Services (HITS) – Interventions / Costs

Phase	Interventions	Cost
Phase I Overall Program	<ul style="list-style-type: none"> ■ 4 Simultaneous HITS Areas ■ 8 HIT Programs per year ■ Approximately 7,000 Targeted Individuals per year ■ Goal: Health Screening, Medical Home & Eligibility 	Year 1 - \$1,577,000 Year 2 - \$1,868,000 Year 3 - \$2,740,000 Total – \$6,185,000
Phase II Preventable Admissions	<ul style="list-style-type: none"> ■ Interact with approximately 1,000 Individuals with Preventable Admissions per year ■ Goals: Initial Triage, Find Medical Home, Disease Mgmt., Eligibility Outreach 	Year 1 – \$130,000 Year 2 – \$135,000 Year 3 – \$141,000 Total - \$406,000
Phase III Avoidable Emergency Services	<ul style="list-style-type: none"> ■ Prioritize and Interact with approximately 2,000 frequent users / high Cost Individuals whose ER Visit could have been avoided. ■ Goal: Redirect 20% to appropriate Medical Home 	Year 1 – \$50,000 Year 2 – \$52,000 Year 3 – \$54,000 Total - \$ 156,000

Health Intervention with Targeted Services (HITS) – Impact/Benefits

Phase	Statewide Impact	District x Department of Health and Memorial Healthcare System Benefit
<p>Phase I Overall Program</p>	<ul style="list-style-type: none"> ■ Pilot Reform Program ■ Improved Health Status ■ Maximize Coverage ■ Maximize Access ■ Minimize Cost of Services ■ Proactive Approach to Reduce Medicaid Costs 	<ul style="list-style-type: none"> ■ Meet our Missions ■ Improved Community Health ■ Appropriate Resource Utilization ■ Maximize Eligibility / Funding ■ Maximizes Cost / Benefit ■ Reduces Reliance on Ad Valorem Taxes
<p>Phase II Preventable Admissions</p>	<ul style="list-style-type: none"> ■ Proactive means to Reduce Uninsured / Medicaid Costs ■ Efficient Use of Resources to Manage individuals with High Cost Chronic Diseases ■ Elimination of Unnecessary Admissions / Costs 	<ul style="list-style-type: none"> ■ Meet our Missions ■ Improved Community Health ■ Appropriate Resource Utilization <ul style="list-style-type: none"> ■ Emergency Room ■ Acute / Tertiary Services ■ Avoidance of Capital Costs ■ Increase Throughput Time ■ Reduces Reliance on Ad Valorem Taxes
<p>Phase III Avoidable Emergency Services</p>	<ul style="list-style-type: none"> ■ Proactive Means to Reduce Uninsured / Medicaid Costs ■ Efficient Use of Resources ■ Elimination of Unnecessary Emergency Room Visit / Costs 	<ul style="list-style-type: none"> ■ Meet our Missions ■ Improved Community Health ■ Appropriate ER Utilization ■ Avoidance of Capital Costs ■ Increase ER Throughput Time ■ Reduces Reliance on Ad Valorem Taxes

Health Intervention with Targeted Services (HITS) Program Request

In order to promote good public health policy, improve the health of the community, maximize eligibility outreach, ensure access to health services, utilize the appropriate level of health resources, minimize the reliance on taxes and continue our drive toward sustainability of this safety net provider; the State of Florida District X Department of Health and the Memorial Healthcare System request matching funding for this 3 year pilot “Health Intervention with Targeted Services (HITS) Program” in accordance with the below table:

Total Individuals Touched per Year	Requested State Funding	Matching Dollars Memorial/Others	Estimated Total Program Cost
Year 1 – 10,000	\$850,000	\$907,000	\$1,757,000
Year 2 – 10,000	\$1,000,000	\$1,055,000	\$2,055,000
Year 3 – 10,000	\$1,000,000	\$1,935,000	\$2,935,000
Total – 30,000	\$2,850,000	\$3,897,000	\$6,747,000

Questions

