Florida Department of Health
Emergency Room Alternative Projects

Presentation to Low Income Pool Council

December 2, 2009

Intent

- Reduce the financial and operational burden on hospitals;

- Improve the health status of low-income uninsured persons by increasing access to appropriate care.

Project Goals

- Redirect persons with low acuity health problems away from hospital ERs to primary care clinics;
- Provide a primary care medical home to the low-income uninsured;
- Provide disease management services to low-income persons with ambulatory care sensitive conditions;
- Link uninsured persons to third party coverage where possible.

Project Components

- Hospital based navigators or formal referral arrangements between hospitals and primary care clinics;

- Expand primary care clinic capacity and operating hours to accommodate hospital referrals and other new primary care enrollees;

- Trained disease management case managers;

Components

- Pharmacy assistance services to provide free or low-cost medications to the low-income uninsured;
- Linkages to specialists through We Care Networks or other volunteer provider organizations;
- Eligibility assistance staff to help people obtain third party coverage.

Project History

- Two projects funded in 2007-08;
- Eleven projects funded in 2008-09;
- Thirteen projects funded in 2009-10;

2009-10 LIP appropriation - $9.5 million

Project Providers – county health departments, federally qualified health centers, rural health network.

Sites – Okaloosa, Jefferson/Madison, Duval, Alachua, Citrus, Lake, Pinellas, Orange, Polk, Hillsborough, Dixie, Sarasota, St. Johns River Rural Health Network.

Cost Savings Potential

- The average charge for a low acuity ER visit in Florida in 2006 for an adult was $1,281;
- The average charge for an inpatient hospitalization for a patient with diabetes in 2006 was $16,079;
- 20 ER diversions per week will eliminate over $1.3 million in hospital charges;
- Eight inpatient hospitalizations avoided per month will eliminate over $1.5 million in hospital charges;
- A fully funded Department of Health ER alternative project costs approximately $750,000.

Project Statewide Summary Statistics

January 1, 2009 through June 30, 2009

Emergency Room Diversions	5,683
Emergency Room and Hospital Referrals	5,593
LIP Patients Provided with a Medical Home	11,415
LIP Patients Enrolled in Disease Management Programs	2,259

Selected Cost Savings*

- 5,683 emergency room diversions were estimated to avoid approximately $7.3 million in ER charges;

- Providing disease management services to 2,259 patients were estimated to avoid approximately $2.5 million in hospital charges ($1,112 savings per patient -- Towers/Perrin Actuarial Analysis, 2005);

- Providing a medical home to 11,415 mostly uninsured people likely avoided significant additional hospital inpatient and emergency room costs.

***These estimates are based on six months of data only.**

Selected Project Results

- Duval -- 74% of hospital referred people were enrolled in a primary care medical home; early data through Jax Health Information Network shows a decrease in hospital utilization for project members;

- Jefferson/Madison – Patient navigator at Tallahassee Memorial; expanded primary care and after hours services; EMS Director reported 275 fewer non-emergent calls and a higher proportion of current transports are true emergencies;

- St. Johns River Rural Health Network – 56.5% reduction in ER usage by enrolled LIP patients (two year pre- and two year post-period);

Selected Project Results

- Orange – door to door outreach to 1301 residences; 624 people linked to primary care medical homes; 217 people enrolled in Medicaid; 248 people linked to disease management services;

- Citrus – supports two urgent care clinics; 58% of urgent care users enroll with Citrus CHD/George A. Dame FQHC as their medical home;

- Sarasota – 88% of hospital-referred people enrolled with Sarasota CHD or North Port FQHC as their primary care medical home.

Key Project Successes

- High proportion of LIP project referrals are enrolled in a primary care medical home and return for subsequent health care services;

- Project patients have much improved access to needed and appropriate health care services;

- Significant expansion of disease management capacity and improved health status of patients;

- Excellent utilization of pharmacy assistance programs that improve patient health and reduce hospital re-admissions.

Project Challenges

- Meeting the need for basic clinical primary care – demand is greatly challenging supply;
- Providing timely access to specialty services;
- Complexity of the disease management patients;
- Transient nature of the LIP population affects continuity of care.

Project Challenges

- Educating the target population on the concept of using a primary care medical home;
- Hiring physicians and nurses at state pay scales;
- Partnerships can be a double-edged sword – usually a great asset but sometimes a liability.

To Where from Here?

- Recommend expansion of primary care/disease management projects;
- Develop more partnerships between hospitals and primary care providers;
- Use primary care/disease management projects to manage high risk patients and reduce hospital readmissions.

Questions?