Lee Memorial Health System LIP Council Update

Low Income Pool - Primary Care Access /ER Diversion and Top 15 Provider Initiative

December 4, 2012

LEE MEMORIAL HEALTH SYSTEM

Lee Memorial Health System

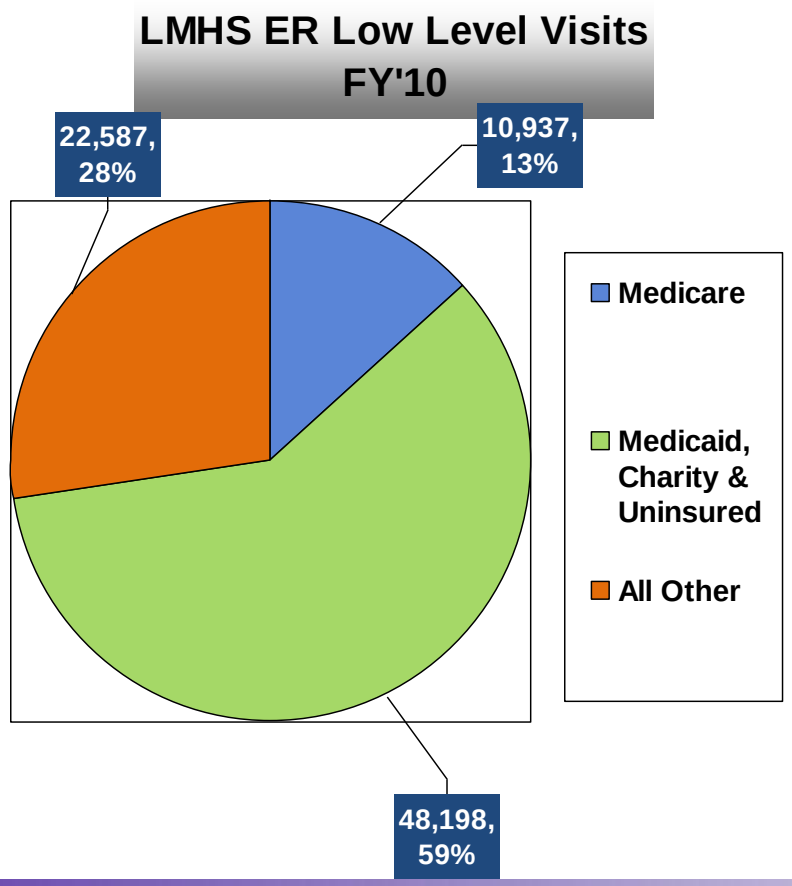
- Founded 1916
- Largest Public Hospital System in the nation with no local tax funding
- SWFL largest health system and largest employer
- 4 acute care hospitals, rehabilitation hospital, Golisano Children's Hospital of SWFL
- Region's only Level II Trauma Center

Safety Net Mission

- 2011 Community Benefit of $223 million, up 40% in the last 5 years
- Only 21% of our patients are covered by commercial health insurance
- 79% are Medicaid, Medicare, uninsured or charity care

- Prior to this LIP Grant Lee Memorial Health System had no community clinics for the uninsured
- Historically the FQHC locally had provided this care
- The increase in uninsured could not be met by the FQHC alone
- Resulted in 82,000 ER visits for unmet primary care needs

Primary Care Access for Low Income Population



Cost of Potentially Avoidable Hospital Admissions

- FY'2011 LMHS twenty five percent of hospital emergency admissions (10,027 patients) were uninsured or underinsured
- LMHS spent $23 million to provide inpatient care to these patients

AHCA Low Income Pool Primary Care / ER Diversion Grant

- Purpose:“…to increase access to primary care services through a program that can reduce health spending and improve health status of the uninsured and underinsured persons in the community by reducing unnecessary ER visits and preventable hospitalization by providing disease management, improving patient compliance and coordinating service..”
- Right care. Right place. Right now.
- Grant Award : $1.5 million annually

Lee Physician Group – United Way House

- New access to primary care services to uninsured low income patients
- Collaboration with the local social service agencies
- First clinic in Dunbar neighborhood
- Second clinic in the North Ft. Myers area
- Open 53 hours weekly at each location

Coordination of Care

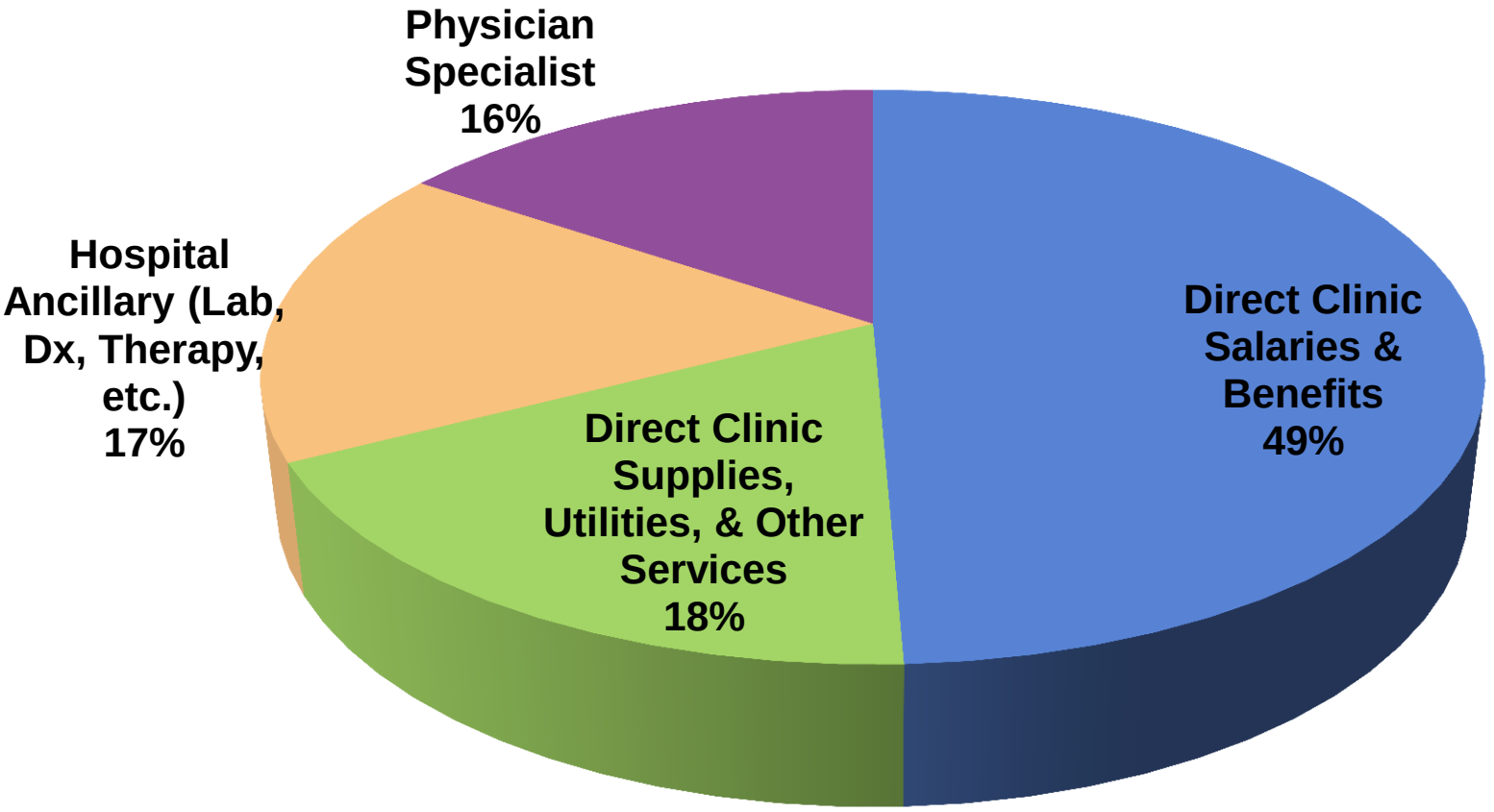
- Emergency room case managers identify patients in need of a primary care physician at discharge from ED or Inpatient Stay
- Appointment blocks were created specifically for ED referrals for follow up care and for Inpatient Discharges
- Community care coordinator follows up with patients to ensure they make it to their appointment.

The Patient Centered Care Team

- A Comprehensive Care Team was established to help navigate patient through all needed health care and social services
- Staffing Model
  - 2 Primary Care Physicians
  - 4 ARNP's
  - 2 Case Managers
  - 1 Community Care Coordinator
  - 5 Customer Service Reps
  - 2 Medical Assistants
  - 1 Radiology Technologist
  - 1 Dietician
  - 3 LPN's
  - 1 Financial Counselor
  - 1 LPN Clinical Supervisor
  - 1 Ambulatory Operations Manager oversees both Clinics
  - Parish Nurse for outreach and translation for Haitian community
  - 2 State Workers to assist with Medicaid eligibility
  - Social services provided by United Way, CCMI, Salvation Army, SWAFAS

Annual Operating Expenses

$1.5 Million LIP Grant Award



Access for Ancillary & Chronic Disease Management Services

- Patients that establish care at our clinics are provided access for all needed lab and diagnostic tests
- Patients with chronic diseases are provided access to chronic disease management services.

Patients Served

- 3,017 unique new low income patients are provided a primary care medical home
  - Previously did not have access to primary care services

- 10,872 total primary care visits
  - Patients of clinic have average 3 – 4 visits per year showing many are compliant with physician's care plan

Impact on Hospital ER Visits and Inpatient Admissions

- Inpatient Admission Reduction
  - 708 fewer charity patient admissions to our hospitals in FY 2012 than in FY 2011
  - 3500 fewer inpatient charity days
- ER visits avoided: estimated between 3,000 and 4,500 (1 to 1.5 per clinic patient)

Patient Mix

- Lesson Learned: Initial forecast was that the clinics would have 50% Medicaid utilization

- Of the 10,872 patient clinic visits,
  - 5 percent (549) were Medicaid
  - 2 percent (216), were Medicare
  - 93% (10,107) were Charity patients that were at 200% of the poverty level or less and did not qualify for Medicaid as childless adults

Most Common Diagnosis

Diabetes
Hypertension
Asthma
Abnormal Radiology Findings
High Cholestoral
Back Disorders
Disc Degeneration
Respiratory Symptoms
Abdominal Pain
Abnormal Blood Test Findings
Disorders of Joint
COPD
Alterations of Consiousness - Dizziness
Aquired Hypothyroidism

Hospital Ancillary Services
FYE: 9/30/2012

Ancillary Services	Patients	
Asthma Management	73	
Cardiology Svcs	184	
Diabetes Management	73	
Lab	948	
Pulmonary Diagnostics	49	
Radiology	365	
Physical Therapy	96	
Mammograms	355	
Total	2,143	

Health Improvements

- Diabetes Management Outcomes (173 patients)
  - 30 Day Readmission Rate
    - 5% Community Care Plan (CCP) Patients attending diabetes classes
    - 14.9% All Diabetes Patients
  - Hemoglobin A1C for CCP Patients attending diabetes classes
    - 8.8% - Initial
    - 7.2% - 3 month follow up

    1.6 point decrease = SIGNIFICANT IMPROVEMENT

    "Each 1 % absolute reduction A1C levels is associated with a 37% decrease in risk of micro-vascular complications and a 21% reduction in the risk of any diabetes related complications or death."

Health Improvements (cont.)

Asthma Management

- 349 units of Asthma Management service provided for patients referred to Asthma Management Program
- Goal of 50% reduction in ED visits and admissions
- Actual reduction approximately 75%

Tier Two Top 15 Hospital LIP Initiatives

Start Date: July 1, 2012

New Low Income Initiatives

- Improve health of obese patients
  (BMI > 35)
- Improve health of patients with COPD
- Improve health of patients with Depression and Cardiovascular disease

Improve Health of Obese Low Income Population

- Screened all patients for patients with BMI >= 35 (703 patients or approximately 1 out of every 4 clinic patients)
- Provide Intensive Behavioral Counseling
- Follow up with weekly dietician visits for four weeks and then two per month for six months
- Prescribed exercise program for 6 months for those who are compliant with the first month of dietician visits
- **Participants:** 74 have been in the program since inception (August 2012).
- **Dietician Visits:** 222 from August-mid November.
- **Six Month Wellness Center Memberships**: 7
- **Outcomes:** Total combined weight loss of 224 lbs and a BMI reduction of 37.5 points.

Improve Health Status of Low Income Patients with COPD

- Improve access to primary, specialty and rehabilitative care services for the treatment of COPD with the goal of relieving and reducing the symptoms as well as reducing the risk of future adverse health events such as exacerbations
- 1st Quarter Results: COPD Uninsured Discharges – 55
  - assigned to PCP – 26 or 47%,
  - Prior year fewer than 5% were assigned to PCP
- Baseline assessments provided in 1st Quarter - 132 patients
- Smoking Cessation Counseling Provided to All Patients with COPD
- Only 3 COPD readmissions in 1st quarter of this new initiative, historically 13 charity readmissions per quarter

Improve Health Status of Low Income Patients with Depression

- Initiate depression screening in clinics to help manage mental and physical health needs and care coordination
  - 134 screenings for quarter ending 9/30/2012
- Identify patients with both depression and other diagnosis such as cardiovascular disease to reduce risk of hospital readmissions through timely and effective treatment plan for their depression
- Provide referral for specialized behavioral health therapy and medication management for those with more severe symptoms

Next Steps

Expand use of Community Coordinator/Case Manager

- Goal to decrease ED visits by 20% for high-frequency/high cost patients, by 6 month follow-up
- Goal to decrease I/P episodes by 10% during first 6 months.
- Connect 100% of patients referred with PCP if patient is willing.

Implement Chronic Disease Self- Management using the Stanford Model best practice

Expand the use of Food Vouchers with food banks and social service agencies

Closing Comments

We believe most of our patients would benefit from the expansion of Medicaid contemplated under the Affordable Care Act.

- Many of these patients need a great deal of care and support since they have not had access to regular primary care
- In reality, the high costs of inappropriate ED treatments are being reprogrammed into community care well beyond primary care alone resulting in little real savings
- Right Care. Right Place. Right Now.