
HMA

HEALTH MANAGEMENT ASSOCIATES

*Manatee County Health Care Plan for
Low-Income Uninsured Adults*

PREPARED FOR
MANATEE COUNTY, FLORIDA

BY
HEALTH MANAGEMENT ASSOCIATES

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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Executive Summary

Health Management Associates was engaged by Manatee County in March 2016 to develop a Manatee County health care plan for low-income uninsured and underinsured adult residents. A Planning Committee was identified and convened four times to provide insight and guidance in an assessment of health and health care needs of the County, and ultimately, the development of the plan. This document presents both the assessment and the Health Care Plan.

Stakeholder Engagement and Assessment

HMA began the engagement by reviewing several relevant documents, and initiating a stakeholder engagement process which continued throughout the course of the project. We met with more than 55 individual community and County leaders representing a wide array of interests. While there was diversity in perspectives related to Manatee County's responsibility for healthcare for low-income uninsured and underinsured adults, several themes emerged. Highlights include the difficulty in accessing primary care, and even greater limitations in dental and mental health/substance abuse treatment capacity for the uninsured. All agreed there were significant assets that could be built on. There was consensus that data needs to be collected more systematically and used more effectively. The safety net health care system is described as fragmented, lacking coordination of care for the low-income uninsured/underinsured. The vision for the "healthcare system" needs to go beyond specific programs to include prevention and health promotion. Finally, while there seem to be several coalitions and consortia related to health, action plans on improving access for the uninsured/underserved seemed to be rarely implemented; this may be due in part to a lack of specificity and detailed implementation plan; lack of specific assignments, champions and accountability for implementation; and limited funding to support the identified goals.

HMA conducted a Community Health Needs Assessment, and found that Manatee County has a low primary care provider to population ratio (1:2504) indicating overall shortage of primary care providers in the County, with a particular shortage of primary care providers serving low-income uninsured adults. The County has a relatively high percent of low income (<200%FPL) 36.31%, a high rate of uninsured in the County (18.03%), and a high percent of adults in the County that report they could not see a doctor in the past year due to cost (16%).

We identified several health indicators of particular concern – those that are above the 75th percentile nation-wide, representing what the federal government refers to as the "severe benchmark." Of those health indicators measured, the following exceed the severe benchmark: diabetes prevalence, diagnosis of high blood pressure, cervical and breast cancer screening, late entry into prenatal care, rates of suicide and drug overdose. Additional health indicators that exceed the national benchmark, and should also be considered for intervention, include rates of cigarette smoking, low birth weight, infant mortality rate, birth to teen mothers, prevalence of HIV and sexually transmitted infection, unintentional injury, and percent of older adults without an influenza vaccine. Another very significant concern is oral health – the percent of adults without dental visit in the last year. While the percent for Manatee County is on

par with statewide rates, it is significantly higher than the national average. These areas were considered while planning the health plan.

We also conducted an asset inventory related to health and health care in the County to ensure that the strengths in the County were built upon to meet the identified needs. There are several health and healthcare planning bodies and partnerships; the Florida Department of Health in Manatee County focuses on prevention and population health; the County is home to a very large and sophisticated Federally Qualified Health Center (Manatee Rural Health) and Community Mental Health Center (Centerstone); there are several hospitals with residency programs; a College of Osteopathic Medicine, School of Pharmacy and School of Dentistry; and 2-1-1 of Manasota serving as a navigation center for health and social services.

HMA conducted an environmental scan to identify and describe several national programs that aligned with the needs in Manatee County to help inform solutions to consider in the health care plan. The scan included successful coverage programs for the uninsured; evidence-based programs to improve appropriate utilization of hospital/emergency services; strategies to help assure appropriate utilization of specialty care; promising behavioral health interventions; strategies to expand dental capacity and access; care management interventions with returns on investment; programs to promote health and linkages with the health care system in Latino communities; efforts targeting pregnancy prevention, prenatal care and pre-term birth; evidence based substance use prevention; and models for integrated delivery systems. We also described organizational structures for the oversight of these types of programs as well as Health Information Technology Infrastructure for care coordination in the safety net.

HMA also assessed Manatee County public, private and community resources that affect access to health care for the uninsured/underinsured residents, and conducted an inventory of Manatee County-wide financial contributions to care of the uninsured/safety net populations, and presented promising financial strategies for the County.

Health Care Plan

In collaboration with the Planning Committee, HMA developed a health care plan narrowly targeting low-income (<200% Federal Poverty Level) uninsured residents due to the limitations in funding expected to be available to support the plan. We included specific recommendations on an organizational and reporting structure to help ensure successful implementation, and indicated that we believe the current IT infrastructure to will need to be revised to encourage maximum provider participation.

The plan is comprised of four goals as well as other issues to be explored. A summary of the goals, objectives and activities are as follows:

Goal 1-Improve access to continuous and coordinated primary care services for low-income (<200 FPL) uninsured adults.

Objective 1.1: Improve primary care access for low-income (<200% FPL) uninsured adults as measured by appointment wait times that do not exceed those required in FL Medicaid managed care contracts.

Objective 1.2: Implement a collaborative care management program to firmly establish high risk/high utilizing low-income (<200% FPL) uninsured adults in a primary care organization focusing on chronic disease management and coordinating with medical sub-specialty, behavioral health, dental and social services.

Goal 2 – Improve access to the appropriate level of mental health and substance use services for low-income (<200% FPL) uninsured adults.

Objective 2.1: Improve access to clinically appropriate care for low-income (<200% FPL) uninsured adults with signs and symptoms of a mental health disorder.

Objective 2.2: Improve access to medically necessary care at the appropriate intensity for low-income (<200% FPL) uninsured adults who have been identified or are suspected of a substance use disorder. While a detailed implementation plan is described for Goals 1 and 2 for the first year, longer term implementation issues are more briefly addressed.

Other goals and areas of exploration include:

Goal 3 – Improve access to dental services for low-income uninsured. Several strategies are presented to expand dental capacity in Manatee County.

Goal 4 – Improve community awareness of safety net health services and coverage opportunities. We included specific strategies around the use of a Navigation Center and outreach programs.

Two additional areas we believe should be explored and considered as the plan is further developed, include: jail health services; and safe, affordable housing.

In summary, we present a detailed implementation plan for the first year that addresses two priority goals, related objectives, and concrete and achievable activities. These activities are expected to collect data and make informed decisions that will improve access to primary care and behavioral health care, help establish individuals in a regular source of care and ensure continuity of that care, and coordinate care for those individuals at greatest risk of poor health outcomes and high (and often preventable) hospital utilization. In addition, the activities call for measurement and tracking of a specific set of metrics to assess progress, and prepare the County to move to a value-based payment methodology with key providers serving the target population. Finally, we describe a major contingency for implementation -- the budget and how budget dollars are recommended to be encumbered for key elements of the plan.

These goals were selected because there is evidence that they are good investments – investments in the residents of Manatee County and the infrastructure that serves them. Successful implementation of any of these goals will involve engagement of County leaders, provider stakeholders, public representatives and others directly impacted by the plan. This short-term implementation schedule was developed to uncover data needed to inform decisions about the plan and to have early successes to build on for the purpose of gaining momentum in taking on new critical areas to meet basic health and healthcare needs of low-income, uninsured adult residents in Manatee County.

Introduction

Health Management Associates was engaged by Manatee County in March 2016 to develop a Manatee County Health Care Plan for Low-Income Uninsured and Underinsured. HMA began by conducting an extensive background document review on the state of healthcare for the uninsured/underinsured, and plans for improvement. Shortly thereafter, at HMA's request, the County identified and convened a Planning Committee to provide insight and guidance to further assessing the health and health care needs of the County, and ultimately, the development of the plan. This document presents the Health Care Plan, and includes all relevant assessments conducted as part of the project, to inform the Plan.

The following guiding principles were developed with the Planning Committee and discussed with County Commissioners, and were used to frame the Health Care Plan.

County funding and/or influence will be used to:

1. Support efforts to enroll all eligible residents in Medicaid and subsidized insurance through the Health Insurance Marketplace* to ensure County funding for health care is the last resort.
2. Support ongoing assessment of healthcare access for the priority population/s, and support/facilitate capacity expansions in critical areas of need. This should include at minimum: primary health care, behavioral health care, and oral health care.
3. Support and incentivize efforts to ensure continuous and coordinated primary care services* for the priority populations.
4. Support efforts to ensure appropriate utilization of health care services with emphasis on the management of chronic conditions to include, at minimum, robust programs in:
 - a. Care management embedded in primary care and community behavioral health, to better manage individuals with chronic conditions that are high utilizers/high risk.*
 - b. Health care navigation to direct people to safety net providers with access, e.g., paramedicine program, community health worker program.
5. Support and facilitate collaboration among safety net providers within the county to create economies of scale and improve funding opportunities. These may include efforts such as care management, primary care/behavioral health integration, coalitions to collaboratively apply for grant funding, etc.
6. Support prevention interventions related to target behaviors that contribute to chronic disease to decrease the burden of disease. These may be interventions that target individuals in worksites, schools, communities, etc.
7. Develop and adopt a funding strategy that secures County and other government dollars and influences the use of community resources to support activities consistent with the County's role.

*See glossary in Appendix A for a definition of terms.

This Health Care Plan is comprised of four goals and other issues to be explored. While there are several other areas of that could be focused on – prevention services, medical sub-specialties, taking on a limited number of goals at one time will be more doable. We have detailed an implementation plan for the first year that addresses two priority goals, related measureable objectives, and concrete and achievable activities. These activities are expected to create an infrastructure for coordinating care for the target population, make significant progress in implementation during the first year, and prepare the County to move to begin to move to a value-based payment methodology with key providers serving the target population.

Successful implementation will involve a comprehensive engagement involving County leaders, provider stakeholders, public representatives and others directly impacted by the plan. The prioritization and sequencing of activities are described in this document for two of four major goals of the health care plan. This short-term implementation plan was developed to uncover data needed to inform decisions about the plan and to have early successes to build on for the purpose of maintaining and increasing buy-in for the plan.

Also described is a major contingency for the implementation -- the budget and how budget dollars are recommended to be encumbered for key elements of the plan. While a detailed implementation plan is described for the first year, longer term implementation issues are more briefly addressed.

Key enabling factors and tasks

Outlined below are a set of key factors that will be critical to success. Many of these key factors are embedded in the set of principles presented to the Manatee County commissioners. Others are based on lessons learned from HMA's previous project development and oversight.

- *Broad stakeholder engagement with public commitment to project goals.* Much of this engagement has already begun through HMA's work to date. During this time, a working group provided a sounding board for HMA, brought enormous experience in health delivery issues in Manatee County to the table, and worked to develop and prioritize the goals. For the implementation phase, an implementation work group should be organized which would include many organizations represented in the current working group. The implementation working group should provide an opportunity for input from key organizations providing safety net care currently in the county. Ongoing involvement by the key provider stakeholders (MCR, Centerstone, Turning Points, We Care, Manatee Memorial Hospital/Lakewood Ranch and Blake Medical Center) should take the form of regular meetings with representation from leadership of these organizations. Subgroups or task forces that may involve other organizations should be organized and detailed to work on each of the specific goals reviewed below. Other stakeholders must also be provided an opportunity to periodically view and vet findings. The Health Care Advisory Board may be one venue to allow for this broader input. Joint County Commissioner and Health Care Advisory Board meetings would allow for periodic updates and check-ins.

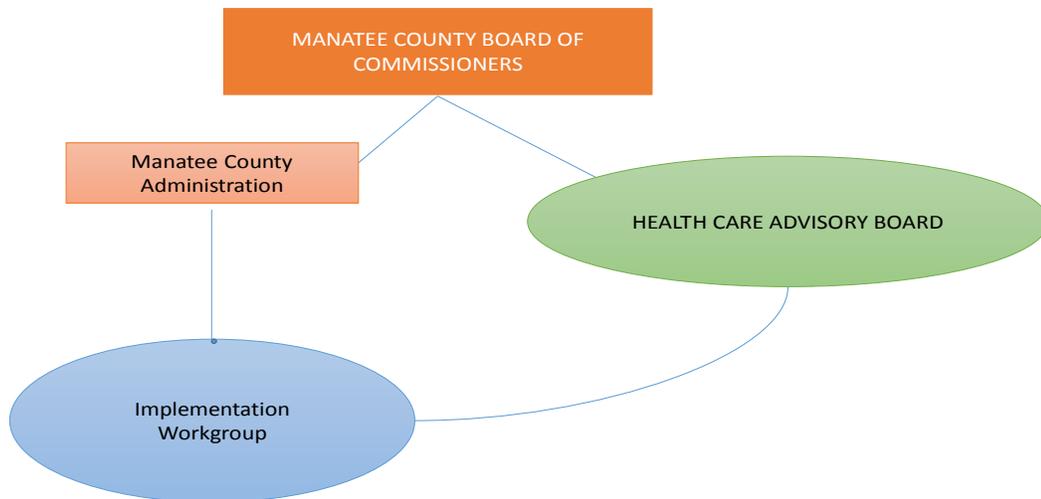
- *Communications -- internally and with the public.* The implementation work group will provide an opportunity for the major provider stakeholders to communicate openly with one another. This open and direct communication is greatly needed. Manatee County can be a neutral party encouraging and soliciting input from these participants. The progress of this initiative should be shared with the public. Larger public meetings provide Manatee County with an opportunity to help shape the discussion about health care for the uninsured and stress key issues. Provider stakeholders may be seen as conflicted due to self-interest should they appear to be leading the implementation initiative. Manatee County staff or other neutral parties should play a prominent role in communication. Manatee County can enhance communication through forums with the Health Care Advisory Board and other open meetings. Through these modes of communication it will be essential to ensure that facts about the roles played by key providers in the care of safety net populations are validated and shared.
- *Dedicated project management team.* This initiative will take substantial work over the next year and longer. Dedicated time must be allocated by Manatee County for participation. It is easier for the County and other providers to plan and allocate this time if the projected commitment can be quantified in hours. The County's new Health Care Services Manager should be a core team participant and should keep track of meeting records and oversee follow-up.
- *Accountability for task completion.* A major criticism heard about previous Manatee County healthcare initiatives was the setting of diffuse goals with overly ambitious objectives. Goals and tasks must be concrete and realizable. Designated follow-up on assigned tasks must be recorded at each meeting and subsequent meetings should review the status of tasks completed, delayed or planned. Accountability for follow-up must be clear at the close of each implementation work group or goal-focused task force meeting.
- *Frequent reassessment of barriers to completion with strategies to overcome them.* It would be naïve to assume that detailed implementation plans can be followed to the letter. Delays and obstacles are inevitable. Within the course of the initiative, issues will arise that must receive the prompt attention of the implementation work group, whether these issues are organizational, budgetary, personal or other. Leadership must ensure that progress continues so that inertia and obstacles do not undermine the plan. The Implementation work group should ideally identify these barriers ahead of time but a flexible and timely response will be of the greatest importance.

Organizational structure and governance

Effectively meeting the health care needs of uninsured residents is a Manatee County government charge that will rely on the efforts of safety net providers, especially, as well as other stakeholders. We see a need for a group of knowledgeable and experienced providers to serve as the implementation work group for this effort. This group should be comprised of representatives from MCR, Centerstone, Turning Points, We Care, Manatee Memorial Hospital/Lakewood Ranch, Blake Medical Center, Armor Correctional Health, the Manatee County Health Department and selected other community service organizations. It would make regular reports to the Health Care Advisory Board. There would be value in having confidential implementation work group meetings to increase the trust of providers, some of

whom have a history of competition, and to share and exchange views in an open manner. We recommend that the scope of this working group be initially limited to developing and implementing a health care plan for the uninsured.

We believe a senior staff of the County should co-chair the group with an executive leader of a relevant community organization. The County’s senior staff person will provide credibility to the County involvement, will be able to ensure provider groups follow through with commitments and can communicate with County leadership, as needed. We propose that the new Manatee County Health Care Services Manager staff the initiative and ensure contact among the participants. Manatee County should own the process of the group. One of Manatee County’s key tasks is to ensure the ongoing participation of key stakeholders. Agenda setting should be done by both Manatee County and any other designated leaders. Budgetary decisions must remain the province of Manatee County government alone, given the involvement of parties who receive Manatee County funds.



There will be a need for task forces that address each of the two major initial goals of the program. These task forces should include content experts in primary care/care management and in behavioral health, respectively. Task forces should report to the implementation work group and, perhaps, directly to the Health Care Advisory Board on a regular basis.

Infrastructure and Information Technology Assessment

The health plan for the uninsured will ideally involve the assessment and sharing of some limited information about the uninsured population of Manatee County. Each safety net provider has their own proprietary information technology/electronic health record system and these systems are currently incapable of sharing information without the investment of sizable resources. Protected health information limits the scope of the information that can be shared among the safety net providers and so any plan for sharing information needs to be limited to what is feasible and appropriate. In addition, the collection of data from providers must be simple and intuitive, drawing on current systems.

Providers do not want to spend duplicative time reentering data into a separate system therefore data exchange must be electronic and verifiable.

Manatee County has a need to obtain claims data from safety net providers for reimbursement purposes. The planned IHS system being implemented in Manatee County appears to primarily focus on claims information. The concept of a Health Information Exchange requires the participation of providers that want to seek County reimbursement for eligible patient claims. Expanding the exchange to add clinical or data processing features deserves further evaluation.

One of the major concerns with the current plan is that many safety net providers have indicated an unwillingness to join this Manatee County information network due to the costs of installation, disruption to existing workflows, etc. While this lack of participation may ultimately reduce claims payments by the county, the goal of a plan for the uninsured would be facilitated by a system that ensured full participation by all safety net providers. Achieving this goal may mean allowing for additional adaptation and implementation time to achieve the potential of the County's health information system plans. We recommend, if financially feasible, removing barriers to participation to ensure participation by all safety net providers.

Data analytics that would help track the progress of programs for the uninsured will be critical to success. Nearly every community across the country is struggling with the same issue confronting Manatee County: how to combine and share data from many providers and IT systems to produce the necessary reports. There are no easy solutions that are both technically and financially simple. The state's Agency for Health Care Administration HIE system can assist in information sharing between providers, but it does not have the ability to store data and will not be sufficient for the needs of this program.

There appear to be some Manatee County resources and staff within the employee benefits and insurance system of the county that have experience with data analytics and assessment. In the next year, we recommend that a part of their time should be engaged or contracted to help redesign the data needs and collection system of the health delivery plan for the uninsured. At a minimum, needed data should include basic demographics, treatment dates at each facility, referrals to other providers, and participation in care management or other special programs for the uninsured envisioned in this proposal below. Participants in the program will need to consent to the sharing of this information, as with any Protected Health Information.

In summary, there is no current method to share the kind of health information needed for the plan for the uninsured. The comprehensive system envisioned for claims processing at Manatee County has functionality limited to claims. In its current state it does not provide the full range of information desired.

Any planned Information Technology platform should reduce or remove financial barriers to participation so that all safety net providers are engaged in the plan. The County should review system needs in light of the current proposal. Current expertise within the County and outside assistance should examine and design the most efficient manner to share this information between safety net providers

and Manatee County. A limited set of information needs, which may not constitute a full HIE system, should be endorsed to assure that meaningful metrics can track and summarize the success of the program.

Timeline Overview – 1 Year Plan

The suggested timeline for project tasks should allow for an ambitious but realistic start to the initiative. We have provided a fairly detailed plan for the first 12 months with more general plans for subsequent years. The vagaries of funding availability, provider organizational change and County leadership changes may make subsequent task identification more tentative however, the provided information for subsequent years identifies the ongoing major objectives in projected sequence.

Goals, Objectives, Measures, Recommendations

Goal 1 – Improve access to continuous and coordinated primary care services for low-income (<200 FPL) uninsured adults.

This goal seeks to establish low-income uninsured adult patients in a primary care medical home to help ensure a continuous relationship with a primary care team and care coordination/management for those patients at greatest risk for poor health outcomes and potentially preventable hospital utilization.

Objective 1.1

Improve primary care access for low-income (<200% FPL) uninsured adults as measured by appointment wait times that do not exceed those required in FL Medicaid managed care contracts.

Background Summary

Manatee County has a low primary care provider to population ratio (1:2504) indicating overall shortage of primary care providers in the County, with a particular shortage of primary care providers that serve low income uninsured. The County has a relatively high percent of low income (<200%FPL) 36.31%, a high rate of uninsured in the County (18.03%), and a high percent of adults in the County that report they could not see a doctor in the past year due to cost (16%).

There are several assets in the County as it relates to the provision (or potential provision) of primary care to this population. These include a large Federally Qualified Health Center (MCR); a large Community Mental Health Center (Centerstone); two hospital-based residency programs (Manatee Memorial and Blake); and two primarily volunteer programs targeting low-income, uninsured adults (Turning Points and WeCare.)

Measures

- Mystery Shopper program assesses access to safety net primary care providers in the County – Manatee County Rural (MCR) Health Services, Turning Points, We Care, Manatee Memorial Hospital, others as identified.

Suggest wait time for next available appointment is consistent with FL Medicaid managed care contracts: Well care visit within one month of the request, Sick care within one week of the request; Urgent care within 1 day of the request.

- Manatee County Health Department obtains and reports on population self-reported measure.

Percent of Manatee County adults (18+ years old) that could not see a doctor in the past year due to cost¹, self-reported national survey.

Suggested target is at or below national average of 13.4% (most recent result for Manatee County is 16%.)

¹ County Health Rankings, 2013

Recommendations

Expand Capacity of Primary Care Providers Serving Low-Income Uninsured

a. Expand FQHC Provider Capacity as Needed.

Determine access levels at which MCR would consider primary care expansion including either new providers and/or new sites. MCR has agreed to consider expansion based on access indicators and that hiring new providers is only “mildly difficult.”

Consider opportunities for the County to assist such as the United States Department of Housing and Urban Development Section 108 loan guarantee program that could finance the construction of healthcare facilities.

Timeframe: Dependent on need based on outcome of baseline measurement. Baseline measurement to begin within 3 months. Mystery shopper assessments will be ongoing following collection of baseline.

b. Residency Training Programs Target Low-Income, Adult Uninsured to the Extent Feasible.

County encourages Manatee Memorial Hospital to empanel a substantial proportion of uninsured in their expanding residency program. Determine target for proportion of unique low-income uninsured patients.

County encourages Blake Medical Center’s new Internal Medicine residency program to provide care for a substantial number of uninsured. Determine target for proportion of unique low-income uninsured patients.

Timeframe: Negotiation to begin within 1 month.

c. Expand Primary Care Volunteerism at We Care and Turning Points for primary (and specialty) care.

County works with the Department of Health to explore sovereign immunity (immunity from civil suit or criminal prosecution) for hospital-based private providers as a strategy to increase volunteerism.

County, Turning Points and We Care develop an outreach plan with messages that highlight sovereign immunity to recruit new providers.

Consider exploring Incentives from an Economic Development standpoint to invest in recruitment of new providers and job creation incentives from EDI. Support the expansion of incentives eligible to targeted medical related industries for equipment and research to attract the right providers/vendors. Consider competing for Federal Economic Development Administration grants to support medical industry job creation and expansion of access to care.

Timeframe: Develop plan and conduct outreach to Medical Society within 5 months.

Workgroup:

- County

- Manatee Memorial Hospital
- Blake Medical Center
- Manatee County Rural Health Services (MCR)
- Turning Points
- We Care
- County
- Bradenton Area Economic Development Corporation
- Career Edge

d. Improve Access to Primary Care for Persons with Behavioral Health Diagnoses

Centerstone and a primary care organization collaborate to co-locate a primary care provider on site at Centerstone to improve access for patients with high behavioral health needs. Centerstone regularly assesses all clients to determine whether they have a primary care provider and are engaged in care. Based on certain criteria, e.g., the severity of the behavioral health issue, the degree of control, the individual's willingness to establish a relationship in a primary care organization, etc. Centerstone will either refer the patient to a primary care provider organization or establish the patient in their co-located primary care provider's practice.

Timeframe: Centerstone will enter into a relationship with a primary care organization to co-locate a PCP at Centerstone within six months. Services will begin within the first year.

Workgroup:

- County
- Primary Care Organization
- Centerstone

Estimated Costs for Objective 1.1:

- Measurement of County health care objective (\$50,000)
- Cost for residency program uninsured – hospital absorbs cost
- Cost for outreach plan to secure more volunteers – participating organizations' time
- Cost for PCP at Centerstone – PCP services are reimbursed via claims submitted to the County
- Behavioral health/primary care integration consultant costs to assist with structure, processes, team-based care training as needed (\$25,000)

Objective 1.2

Implement a collaborative care management program to firmly establish high risk/high utilizing low-income (<200% FPL) uninsured adults in a primary care organization focusing on chronic disease management and coordinating with medical sub-specialty, behavioral health, dental and social services.

Background Summary

Challenges: In any particular population, a small sub-set of the population uses the majority of the healthcare dollars. These high cost populations are often comprised of individuals with multiple chronic conditions which may include behavioral health issues. This population is not necessarily established in ongoing primary care, may not have access to medications or skills or the appropriate environment to be able to manage their conditions, and uses the hospital as a main provider of care when they are in crisis.

Assets: Manatee County has a primary care and behavioral health care safety net with some experience and interest in implementing an evidence-based care management program.

Measures

- Participating Primary Care Organizations Measure Process:
 - Number of uninsured adults <200% FPL enrolled at site
 - Number health risk assessments conducted annually on uninsured adults <200% FPL
 - Number of uninsured adults <200% FPL that meet criteria for “benefiting from a care management program” including number of patients assessed at particular levels of defined risk
 - Number patients enrolled in care management out of those that meet criteria for “benefiting from a care management program”
 - Number patients with care plans developed and being implemented
- Manatee Memorial Hospital Measures and Trends Outcomes:
 - Number of ED visits for ambulatory care sensitive conditions (ACS conditions) for uninsured adults <200% FPL per population in CM program; trend from time period prior to enrollment in CM program
 - Number of hospitalizations for ACS conditions for uninsured adults <200% FPL per population in CM program; trend from time period prior to enrollment in CM program
 - Number of readmissions for ACS conditions for uninsured adults <200% FPL per population in CM program; trend from time period prior to enrollment in CM program

Recommendations:

- Identify invested organization to sponsor (use their infrastructure to support) the care management program for the County’s priority population.
- Establish agreement for collaboration among stakeholders.
- Create program structure and tools including health risk assessment, care plan and technology platform (if desired) to support the effort.
- Develop a systematic approach to identifying individuals of the eligible population needing care management.
- Use stratification tools and criteria to subset the individuals according to risk, needs, and levels of care management intervention.
- Identify the target staff to individual ratio for care managers based on varying levels of need and risk stratification.
- Create a care management model with interventions appropriate for risk level that uses care plans and other tools to support each level of care needed.

- Identify existing staff/hire new staff.
- Develop and conduct a training and support program for front line care managers and their supervisors.
- Develop linkages to primary care, specialty care, acute care settings, the jail, and community resources.
- Enroll those clients at highest risk into the care management program and begin frequent engagement/contact both face-to-face and telephonic/virtual.
- Refine and routinely review a dashboard of indicators of success (process and outcome.)
- Monitor the care management program for fidelity to the model through data and chart review.
- Manatee County supports the program through one or more means: re-directs existing funds, supports with new funds, and/or incentivizes attainment of measures.

Timeframe:

- Plan and build program infrastructure in participating organizations within 6 months.
- Hire and train staff within 9 months.
- Initiate program within 9 months.

Workgroup:

- County
- Manatee Memorial Hospital
- MCR
- Centerstone
- Turning Points
- We Care
- Armor

Estimated Cost for Objective 1.2:

Consultant to work with workgroup to plan structure, with each organization, collaboratively develop workflows and build infrastructure for care plans; develop common set of care management program tools; and train care managers and their supervisors. Approximately \$120,000.

Fund RN and/or LCSW care managers at approximately \$100,000 per care manager annually (this number includes benefits). A portion of these funds might be used to pay incentives for meeting care management process measures – helping to move Manatee County funding for healthcare to move toward more of a pay for performance model. Depending on the complexity of the patient population, caseloads are estimated to be 40 - 100 (with 60-80 as the typical range) for one care manager.

Goal 2 – Improve access to the appropriate level of mental health and substance use services for low-income (<200% FPL) uninsured adults.

Background Summary

Centerstone offers a comprehensive array of services, both inpatient and outpatient, to meet the behavioral health treatments needs of Manatee County residents. Funded through a combination of Federal, State, County, and grant funds, Centerstone strives to meet the needs of every person who seeks care regardless of their ability to pay. They are the sole provider of residential substance use disorder treatment and detox. In 2015, they added six Addiction Center beds, and they have renovated their hospital to add seven in September of 2016. A six-bed expansion of its crisis center is scheduled for completion in May of 2017.

Mental health care is available from two other community providers. Psychiatric evaluation, medication management, and outpatient individual therapy is available in a more limited fashion from MCR. Inpatient psychiatric beds are available at Suncoast Behavioral Health Center, a free-standing psychiatric hospital that also provides partial hospitalization for mental health conditions.

For individuals with need for the highest intensity of mental health services, resources are limited. Inpatient bed capacity is full at times, leading people to be housed in the ED until a bed becomes available, transferred out of the county, or taken to jail. Assertive Community Treatment teams and the Intensive Outpatient Treatment Program offered only at Centerstone provide comprehensive care to adults with serious mental illness but have limited capacity and do not fully meet the needs of Manatee County. Centerstone has applied for a grant, supported by the Public Safety Coordinating Council, for a Supervised Release Program diverting justice-involved people with mental illness to release under Centerstone's care.

When a person is not at risk of harm to self or others and is not displaying signs of psychosis, care is available but may be at an intensity level or frequency below that which is recommended clinically. Current data collection methods do not allow for observation of this practice, thereby leading to data that shows little-to-no access issues, despite frequent anecdotal reports of the contrary.

As noted above, Centerstone is the only provider of inpatient and residential substance use disorder treatment in Manatee County for the priority population. Centerstone also offers outpatient services. An additional provider, Operation PAR, offers outpatient substance use disorder services, mostly notably operating a methadone clinic. Centerstone rounds out Manatee's Medication Assisted Treatment options with Suboxone and Vivitrol.

Manatee County was not immune to the opioid epidemic facing the nation and has taken steps to address the problem. Despite efforts by service providers, the County, Drug Free Manatee, and other health care providers, the need for treatment - particularly residential treatment beds - has been inadequate to address the need in the community.

Objective 2.1

Improve access to clinically appropriate care for low-income (<200% FPL) uninsured adults with signs and symptoms of a mental health disorder.

Measures

- The percentage of people who received the level of care indicated by their assessment as the first intervention.

Data source: Mental health providers that receive County funding to collect assessment and referral data in order to track and trend limited availability of clinically appropriate services (e.g. FACT).

Target: Achieve a 10% improvement in the percentage of people who receive the level of care indicated by their assessment as the first intervention.

- The number of days per month with no adult inpatient beds available for mental health treatment.

Data Source: Census data for Centerstone and Suncoast Behavioral Health.

Data Source: Consider collecting disposition data from emergency departments, EMS, and law enforcement to identify instances where people were held in the ED, taken to jail, or sent out of the county for treatment because there were no beds available.

Target: Month over month improvement with an ultimate target of 0 days of no available capacity.

- The percentage of arrests for people with an identified mental health disorder that were potentially divertible.

Data Source: The Public Safety Coordinating Council should develop a list of potentially divertible arrests and methods for collecting data. Examples may include charges such as loitering, disorderly conduct, and trespassing. Consult with the Acute Care Committee for people under the Marchman Act to determine if efficiencies can be gained.

Goal: To be determined

Recommendations

a. Fund mental health services that address the level of need in the community.

In order to better understand how mental health services for the target population are funded in Manatee County and at what level they are currently provided, required reporting for mental health providers receiving County funding should be modified as follows:

Clearly identify how County funds are distributed and used across the provider's budget

Report service utilization at the individual and service level for people in the County's target population (uninsured, <200% FPL).

Explore options for additional funding or reassignment of funding for services which are determined to have insufficient access. Work closely with Central Florida Behavioral Health Network on this approach.

If it is determined that inpatient capacity is lacking, consider providing County funding to Suncoast Behavioral Health to open additional beds for the target population and to transport individuals to that facility.

Consider a County or philanthropy-funded grant writer consultant to maximize opportunities to obtain grant funds. The specified goal of the engagement would be a completed grant proposal.

Timeframe: Modify reporting requirements within 60 days. For access measures, develop a methodology for collection and train staff who will be reporting and collecting data during the first month, with an additional month to adjust and retrain as needed. The next three months of data collection will serve as baseline. Identify needs for additional funding or funding realignment for the next budget cycle.

b. Identify and provide for the mental health needs of those in primary care and the primary care needs of those in specialty mental health care.

Prioritize the use of specialty mental health resources for those members of the target population who cannot be safely and effectively treated in the primary care setting by capitalizing on other sources of care, such as primary care settings, for treatment of mild to moderate mental health disorders. Create a protocol to assist both behavioral health and primary care providers with determining the appropriate source of care.

Consider piloting with one or more primary care practices the practice of co-locating a Licensed Clinical Social Worker or Licensed Mental Health Therapist in the primary care clinic to deliver a collaborative care model such as the IMPACT Model.²

Implement a requirement that all members of the target population seen in a primary care setting be administered a standardized screening for symptoms of a mental health disorder. Appropriate screening tools may include the PHQ-9 and the GAD-7.

Primary care practices should establish consulting psychiatrist relationships to better support management of mild to moderate mental health disorders in the primary care setting.

Timeframe:

- Develop the protocol within five months.
- Establish pathways for reciprocal referrals between behavioral health and primary care within six months.
- Identify practices that are amenable to co-locating a therapist within 90 days; have therapists in place within 9 months.
- Institute mental health screenings within six months.

² <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=301>

- Establish consulting psychiatrist relationships within 9 months.
- c. Continue efforts to reduce the arrest of people with serious mental illness for crimes that could potentially be diverted.**

Ensure that the Public Safety Coordinating Council has a standing agenda item to address the need for and success of referring people displaying signs and symptoms of mental illness for assessment as an alternative to arrest.

Promote mental health advanced directives for people with serious mental illness who are justice-involved to allow for a previously agreed upon course of action to readily be in place during a crisis.

As a longer term strategy, consider implementation of a mental health court for Manatee County. Manatee County already has a drug court in place. A companion mental health court would offer a similar option to divert individuals with an identified mental illness from the justice system into treatment.

Timeframe: Identify arrest data methodology and collection plan within nine months. Centerstone should implement mental health advanced directives, prioritizing justice-involved individuals, within nine months. Consider funding a mental health court for the 2017-2018 budget cycle.

Workgroup:

- County
- Centerstone
- Central Florida Behavioral Health Network
- Suncoast Behavioral Health Center
- MCR, Turning Points, We Care
- Law Enforcement

Estimated Cost for Objective 2.1:

Mental health access measures and reporting changes will be collected within existing resources.

Analysis of arrest diversion programs: \$50,000 for analysis and reporting by a state university or other appropriate entity.

Mental health court: The general range of a SAMHSA grant to support the development of a mental health court is \$300,000 – \$400,000. The annual cost of operating the mental health court in Leon County, FL, was approximately \$250,000.

Objective 2.2

Improve access to medically necessary care at the appropriate intensity for low-income (<200% FPL) uninsured adults who have been identified or are suspected of a substance use disorder.

Measures

- The percentage of people who received the level of care indicated by their assessment as the first intervention.

Data source: Centerstone to collect assessment and referral data in order to track and trend limited availability of clinically appropriate services (e.g. residential substance use disorder treatment).

Achieve a 10% improvement in the percentage of people who receive the level of care indicated by their assessment as the first intervention.

- The number of days per month with no adult detox and residential beds available for substance use disorder treatment.

Data source: Census data for Centerstone.

Data source: Consider collecting disposition data from emergency departments, EMS, and law enforcement to identify instances where people were held in the ED, taken to jail, or sent out of the county for treatment because there were no beds available.

Target month over month improvement with an ultimate goal of 0 days with no available capacity.

- The number of people participating in Medication Assisted Treatment (MAT) – include measures of those who initiate and those who are adherent at 30 days, 90 days, and six months

Data source: Centerstone and Operation PAR will report on the number of people in the target population participating in MAT.

Of available MAT resources, suggested targeting at least 80 percent used for a target.

The number of people who initiate MAT and who are participating at 30 days, 90 days, and six months will increase over time.

Recommendations

a. Fund substance use disorder services that address the level of need in the community.

Consider a County or philanthropy-funded grant writer consultant to maximize opportunities to obtain grant funds. The specified goal of the engagement would be a completed grant proposal.

Explore additional funding sources, to include grants, county funding, etc., to expand residential capacity, working closely with Central Florida Behavioral Health Network.

Timeframe: Informed by access and treatment need data that is gathered during Year 1, develop a proposal to expand residential substance use disorder treatment and related funding needs for the next budget cycle.

b. Promote Medication Assisted Treatment, to include Methodone, Suboxone, and Vivitrol (for individuals who have completed detox)

Provide education on MAT, including a description of the treatment modality and effectiveness information, to individuals seeking care, substance use disorder treatment providers (other than MAT), and referral sources.

Implement a quality improvement project with MAT providers to improve retention of program participants.

Timeframe: Develop an educational program in the first quarter of 2017. Educate providers and referral sources in quarters 1 and 2. Implement a quality improvement project in Year 2.

Workgroup:

- County
- Centerstone
- Operation PAR
- Central Florida Behavioral Health Network
- Drug Free Manatee

Estimated Cost for Objective 2.2:

Expanding Substance Use Disorder Treatment: to be determined

Promote MAT: to be completed with existing resources of Centerstone, Operation PAR, and Central Florida Behavioral Health Network.

Goal 1 and 2 Supplemental Information

Chronic Care Management

Individuals with multiple chronic conditions comprise a disproportionate share of health spending in this country. Chronic medical conditions account for more than 75 percent of total health spending. One quarter of US adults have multiple chronic conditions and 20-50 percent of them have co-existing depression. Chronic medical conditions associated with modifiable behavioral risk factors such as smoking, obesity, nutrition and physical activity represent six of the ten costliest medical conditions in the US.

While creating a comprehensive care management program is an ambitious process, below is a short-term strategy we believe will be effective in addressing high costs associated with the uninsured, low-income <200% FPL, adult population.

Instead of forming a new 501c3 that would require a large investment of funds to sponsor the care management program, we believe an invested, existing organization could potentially serve in this role. The contact between the County and participating organizations can either re-direct existing funds to cover the cost of the program, provide funding to cover all or some of the cost of the program, and/or incentivize meeting measures of success.

The Care Managers (CMs) would be placed (the vast majority of their time) in primary care at the residency programs, MCR, Turning Points, Centerstone, and perhaps We Care and the hospital emergency departments. The Program will develop systems to identify individuals receiving care in the hospitals to enroll in primary care, and if eligible, enroll in the care management program. The Program will also develop systems to identify individuals already receiving care in these primary care settings that would be eligible to enroll in the care management program. The CM will supplement/complement any existing care management capacity with a sole focus on low-income uninsured <200% FPL. The County-funded CMs can collaborate with existing care management programs in these sites to enhance both programs over time.

The organizational sponsor would provide the administrative infrastructure to operate the program – payroll, human resources, training space, etc. to reduce the administrative burden of creating a new organization. The sponsor would partner with the participating organizations to recruit, hire and supervise the CMs.

A fully operational integrated care management program should include a network of medical, behavioral health and social service providers to support implementation of a seamless network of population- based services. The goal of such a program will be to coordinate the care of recipients of services providing the right care at the right time in the most efficient manner. While some of the provider organizations in the County may have care managers, we recommend the County financially support the program to specifically target the low-income (<200% FPL), uninsured adults.

We recommend a more standardized program across the major safety net primary care provider organizations that is based on evidence and best practice.

While there are several steps to developing a care management program, the following is a list of key steps followed by further description.

1. Create a systematic approach to identifying individuals in the eligible population that could benefit from care management.
2. Use stratification tools and criteria to subset the population according to risk, needs, and levels of care management intervention.
3. Create a care management model that crosses various intervention levels with care plans and other tools to support each level of care needed.
4. Develop and conduct a training program and ongoing support system for CMs.
5. Develop linkages to primary care, acute care settings, behavioral health providers, oral health providers, and other community resources.
6. Develop and routinely review a dashboard of indicators of success.

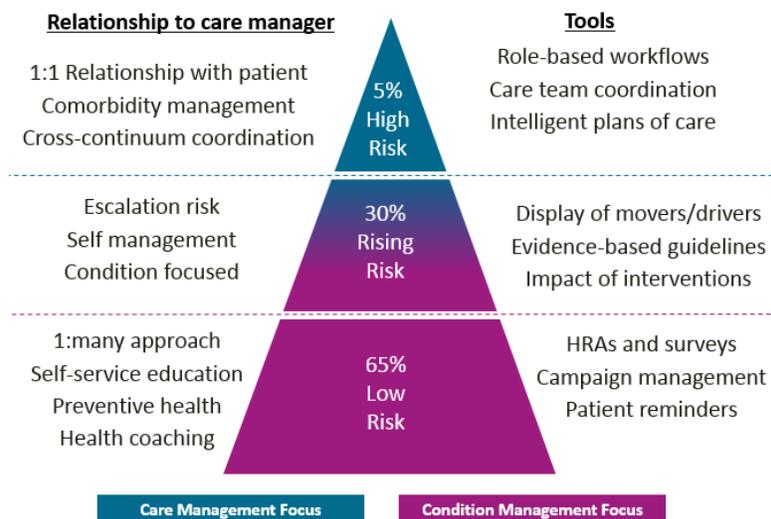
Identification and Stratification

The first step in developing a more robust program is to create a process for identifying the individuals who can most benefit from care management, with the goal of improving health care outcomes, and

reducing preventable utilization of services and reducing costs. Recommend that hospitals identify individuals who visit the ED frequently, particularly for non-emergent conditions, and people with evidence of high-cost or uncoordinated care for complex conditions. The hospitals will be incentivized to refer identified individuals to a CM in the most appropriate setting for the individual’s needs, such as primary care or behavioral health. Those experiencing homelessness, for example, may be most appropriately referred to a CM at Turning Points. CMs will conduct an in-person interview with the referred individual and complete a comprehensive health risk assessment.

Based on the risk assessment results and utilization data, each individual is to be assigned a health risk level of low, medium or high. Based on that risk level, the CM will assign the individual to regular care only or enroll the patient in the care management program with their consent. The CM will ensure that the person is assigned to the care management intervention level appropriate for their needs. The health risk assessment data will be used to work with individuals to develop a personalized care plan that reflects the appropriate level of service need.

The figure below depicts an example of patient segmentation along with the types of care management relationships and tools appropriate for each risk level. For this example patient population, the top of the pyramid represents the highest risk at approximately 5 percent of patients; the middle represents a rising risk population of about 30 percent; and the base of the pyramid represents a lower risk patient population of about 65 percent.



Source for Figure: Vicky Harter. Population Health: The Caradigm Perspective. Care Management. May 17, 2016.

Creation of a Care Management Model for Intervention Levels

- Specific intervention models should be developed for each level of care to reflect the variations in service requirements and intensity of care oversight. Interventions may include activities such as medication reconciliation, education about the person’s health care condition and improved health literacy, and addressing social determinants of health such as food security and

stable housing. Adding a “Housing First” element to the model for this target group can provide a significant level of ED visit reduction and cost savings that can potentially be directed towards housing subsidies.

Care management protocols should be developed to provide standards of care and guide the care management plan with regard to frequency of contact, communications with the primary care team, care planning documents and updates, intervention steps, community outreach and referrals, self-management tools and goal setting.

- “Hot spotting” the identification of geographic areas where the demand for specific services and care management needs are highest can also be used to drive decisions about where to place care managers.

Training, Preparing and Supporting Care Managers

Participating providers will need to update job descriptions, hire care management staff based on staff to individual ratio requirements, and develop a care management training program. To ensure staff meet specific competency requirements, training modules should include at a minimum:

- Self-management
- Motivational interviewing
- Behavioral activation
- Shared decision making
- Screening, Brief Intervention and Referral to Treatment (SBIRT) training which is an evidence-based practice used to identify, reduce and prevent problematic use, abuse, and dependence on alcohol and illicit drugs
- Development of a care plan and use of care guides and evidence-based protocols (including protocols for behavioral health conditions such as depression, anxiety, bipolar disorder, and schizophrenia)
- Communication among the health care team

Linkages to the Primary Care Provider

One of the most effective care management strategies is the use of embedded care managers in primary care offices with a high number of individuals requiring care management services. While some provider education about this strategy may need to occur, most providers are generally receptive to this strategy. Embedded care managers will need to clearly understand both their responsibilities and limitations, and respect the lines of authority within the provider’s office environment. Clear delineation of roles for providers, CMs, and clients is critical to the success of this strategy. Protocols and planning documents should address each participant’s responsibilities and communication expectations as it relates to development, monitoring, and implementation of the individual’s care plan.

Measures of Success

The care management program will need measures of success to track progress and identify areas requiring adjustment. These will include process and outcome measures that will be developed, agreed upon, routinely collected and reviewed to determine program modifications.

Behavioral Health Integration

It is estimated that 20% of the population in the United States will need behavioral health intervention or treatment yearly and that 5% of the population suffers from serious mental illness. However, the prevalence of mental and substance use disorders will differ widely among different populations depending on factors such as age, race, socio-economic status, and ethnicity.

Many mental health or substance use conditions are effectively managed within a primary care setting. However, it is widely acknowledged that these conditions are underdiagnosed and, therefore, inadequately addressed. Every patient in a primary care practice should be screened to identify behavioral health conditions. The intake assessment should identify past history of diagnoses, hospitalizations, and treatment for these conditions. Assessment should be repeated at scheduled intervals to capture changes in patients' needs. Because of the high prevalence of depression, all members of a Patient-Centered Medical Home (PCMH) should be screened annually for this condition. One useful instrument is the PHQ-9, although others may be used. Beyond screening, a PCMH must be adequately prepared to provide evidence-based clinical treatment of identified needs, as well as care management and care coordination appropriate for behavioral health issues.

Collaborative care is perhaps the most effective method for providing mental health, behavioral health, and substance use disorder services within primary care. The IMPACT Model is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration that is an example of collaborative care for depression in primary care; however, this approach can be applied to other conditions, such as Post-Traumatic Stress Disorder or anxiety disorders. In this model, universal primary care screening for specific behavioral conditions is followed by a brief, standardized primary care diagnostic assessment for those who screen positive. The medical home team functions in two main ways: 1) the individual's primary care physician works with a care manager/behavioral health specialist to develop and implement a treatment plan, and 2) the care manager/behavioral health specialist and primary care provider consult with the psychiatrist to change treatment plans if individuals do not improve. A patient registry³ is used to prompt follow-up sessions and outreach and to track behavioral health outcomes. Providers treating either primary care or behavioral health patients should use available tools to screen for substance use. They should provide brief interventions effective in treating patients identified with problematic or risky substance use.

Behavioral Health Specialty Providers

Patients with severe and complex mental illness, at risk of harm to self or others, or with symptoms of a behavioral health disorder that have not been responsive to treatment provided by the primary care practitioner should be referred to a behavioral health treatment provider. For the highest likelihood of positive outcomes, behavioral health providers should employ evidence-based models of care with fidelity to those models.

³ A patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves a predetermined scientific, clinical, or policy purpose(s). Citation: Gliklich RE, Dreyer NA: Registries for Evaluating Patient Registries: A User's Guide: AHRQ publication No. 07-EHC001. Rockville, MD. April 2007

To improve health and control health care costs for individuals with serious behavioral health conditions, it is critical to recognize that comorbidity with chronic physical conditions is common. Severe mental illnesses, such as schizophrenia or bipolar disorders, are associated with excessive morbidity and early mortality from physical conditions such as heart disease, metabolic disorders, and cancer. Likewise, the effects of unrecognized depression, anxiety, and substance use disorder are among the most prominent contributors to poor control of chronic physical illness.

Unfortunately, behavioral health and physical health needs traditionally have been managed and treated in separate systems with inadequate coordination for a person’s total care.

Practitioners in both primary care and behavioral health have reported feeling unprepared to address the clinical issues with each other and lack time and readily available methods to communicate across their professional boundaries.

Integration of Behavioral and Physical Health

Integrating behavioral health and primary care can improve health outcomes and help avoid excess cost for individuals with behavioral health issues, especially those with co-occurring chronic conditions. It is helpful to have a conceptual model of treatment before proceeding to actual integration within a delivery system. Complete integration of primary care and behavioral health into one health care unit offers the most potential for delivering the highest quality, lowest cost of care. However, usually the primary care and specialty behavioral health resources and services operate separately within different organizations. The challenge, then, is to design care delivery that effectively identifies persons with co-occurring conditions (usually from screening) in both physical and behavioral health settings— and delivers the needed care.

Achieving this goal will require:

1. planning where patients receive care for each condition
2. ensuring that there is coordination, communication, and collaboration between each clinical site involved
3. providing a system of care management for this population.

Identifying Where an Individual Receives Care

For patients with both physical and behavioral conditions, care for both conditions must be provided at one main site. This facility will be the entity where the individual spends—or chooses to spend—the most time. The primary site coordinates care and is the site of accountability. The Four Quadrant Integrated Model (shown below) is a helpful planning tool. While it is not prescriptive, it can help guide the decision-making process for where care might best be provided for persons with both physical and behavioral conditions.



Low Mental Health Needs/ Low Physical Health Needs	High Mental Health Needs/ Low Physical Health Needs
III.	IV.
Low Mental Health Needs/ High Physical Health Needs	High Mental Health Needs/ High Physical Health Needs

Health Needs

Traditionally, persons in Quadrants I and III are the most appropriate candidates for care provided in a PCMH. Persons in Quadrant II are most appropriate for care within a behavioral health organization. Persons in Quadrant IV represent a particular challenge since they have severe and persistent behavioral health issues as well as severe, complex, and chronic physical illnesses. Interpreters of the Four Quadrant model often indicate that specialty behavioral health centers are ideal for those in Quadrant IV.

Fully integrated teams have the expertise to prepare and implement a care plan that is truly patient-centered and shared by everyone who cares for the patient. They use the same records, plan together, and work as one team.

Models of Integration

There are several models that represent different levels of integration. Experience in each of these models offers insight about their effectiveness and the kind of system redesign needed to implement them. Each model requires new staff roles and competencies, as well as retraining or hiring new staff. The three levels of integration are: collaboration of services, co-location of services, and fully integrated models.

Collaboration of Services

This is the first level of integration between independent primary care and behavioral health entities located in separate places. At this level, the two entities relate to each other via referrals which they use to delegate aspects of care. There are agreements and processes that define and facilitate referrals in both directions, and communication occurs on individual cases with release of information sought each time. In addition, there is some formal attempt to understand and define each entity’s role and model of care.

Expanded duties for each are usually included (e.g., screening for medical conditions in the behavioral health entity or psychiatric medication management in primary care). Care management staff at each entity has a particular role in fostering and supporting the collaboration. One entity is designated the Health Home. The other entity has more of a secondary role as a consultant. Information technology, databases, and medical records are separate. Reimbursement and governance are typically separate, and true sharing of a care plan is not complete.

Co-location of Services

Close consultation between primary care and behavioral health in a collaborative model is an improvement over current practice. However, many health systems have found gaps in continuity and communication that can negatively impact patient care. When services are separately located, some duplication of services and costs are unavoidable. Patients cannot receive their needed care without some travel and must become accustomed to a second location's design and processes. As a result, important and effective services can be missed. To address this, systems have co-located a practitioner in the other setting to serve patients with co-occurring conditions.

Often a primary care nurse practitioner is embedded in a behavioral health setting, or a licensed clinical social worker is embedded in a primary care setting. This improves patient convenience and enhances the use of informal consultation between staff. The embedded practitioner provides care with the collaboration and consultation of a psychiatrist or primary care physician at their "home" site. The embedded clinician may serve to support collaborative care models or provide direct treatment and service to a limited case load. The clinician also acts as a liaison between the entities. The informal relationships the clinician maintains help increase understanding and communication. Patients are more likely to adhere to scheduled visits with this one-stop arrangement and a warm hand off that can occur upon referral to the embedded clinician.

However, this is not full integration. Medical records usually are separate, as is billing and the reporting and evaluation of the practitioner to another facility. While the nurse practitioner or licensed clinical social worker is embedded in another setting, they are not actually full-fledged members of that care team. Communication is improved, but formal communication approaches, such as a shared care plan, are usually lacking. One of the entities is responsible for patient care and coordination of care and outcomes, no matter where the care is delivered. Substantial agreement must occur between the facilities on policies, designation of responsibilities, availability, and access.

Fully Integrated Models

Although it is not widespread, the fully integrated approach treats all persons with mental illness, including serious mental illness, in one organization that contains both primary care and subspecialty behavioral health. These clinical services are integrated, and the single entity is responsible for governance, administration, and financing. The design of integrated services is simply the design of the organization's model of care and an organization-wide effort. Behavioral health and primary care providers are on the same staff and interact frequently. They share a single medical record, care plan, information system, database, and quality program.

Perhaps the greatest challenges to integration are the different cultures, work styles, and practice paces of behavioral health and primary care. For instance, primary care has developed much more of a population focus, while behavioral health is more focused on the individual. Moving the two kinds of organizations toward fuller integration is not an easy task, but evaluations of organizations with high levels of integration indicate health outcomes improve and costs decline.

Manatee County Implementation Plan: Year 1

Task		2016				2017									
		9	10	11	12	1	2	3	4	5	6	7	8	9	
1.1	Primary Care Provider Access														
1-a	Baseline/If Not Meeting Measure, Consider FQHC Expansion														
1.1	Ongoing Access Measurement through														
1-a	Mystery Shopper														
1.1	Residency Program Negotiations with														
1-b	Manatee and Blake														
1.1	Outreach plan to Medical Society for														
1-c	volunteerism														
1.1	Co-location of primary care at														
2	Centerstone														
1.2	Build Care Management (CM) Program														
	Infrastructure														
1.2	Hire and Train CM Staff														
1.2	Initiate CM Program/Initiating														
	Monitoring of Program														
2.1	Modify reporting structure for														
a	Centerstone														
2.1	Train behavioral health (BH)														
a	assessment staff on collection of BH														
	access measures														
2.1	Adjust BH measure collection and														
a	retrain staff as needed														
2.1	BH data baseline														
2.1	Assess need for additional BH funds														
a															
2.1	Identify BH Integration Champion														
b															
2.1	Establish BH Referral Protocol														
b															
2.1	Establish pathways for reciprocal														
b	referrals for BH treatment														
2.1	Develop arrest data methodology and														
c	collection plan														
2.1	Implement mental health advanced														
c	directives														
2.1	Consider mental health court														
c															
2.2	Identify and develop an agreement														
a	with a grant writer that spans 10/1-														
	9/30/17														

Task		2016				2017								
		9	10	11	12	1	2	3	4	5	6	7	8	9
2.2 a	Develop a proposal to request county funding to expand residential substance use disorder treatment													
2.2 b	Develop a Medication Assisted Treatment (MAT) educational program													
2.2 b	Education providers and referral sources on MAT													

Manatee County Health Care Budget for Fiscal Year 16-17

In beginning the transition to a more coordinated health care delivery system, Manatee County needs to structure the Health Care budget to make that possible. Since FY 16-17 will be the beginning of this restructuring, significant changes relative to the FY 15-16 budget are not recommended.

There are two alternative scenarios presented which are described in more detail, but the primary objectives in developing these for consideration by the County are:

- Maintaining the overall Health Care budget at a level consistent with FY 15-16, which is approximately \$23 million.
- Maintaining the current funding streams in order to minimize disruption to the major partners of the County that provide health care to the citizens of Manatee County. Funding for future years will need to be re-evaluated as the changes to health care in the County occur.
- Maintain an adequate level of reserves in regard to health care.
- Providing funding for the new initiative to begin the restructuring of County funded health care.
- Maintaining County flexibility in years after FY 16-17 by not proposing major funding for new recurring programs, which if implemented, might limit the County's ability to make future funding decisions needed as health care is restructured.

Manatee County, by state statute and local law, must fund certain programs related to health care. The most significant expenditures related to this are for health care at the county jail, funding for the county health department, and specified local match for the Florida Medicaid program. The funding for those items for FY 16-17 is estimated to be \$12.4 million. The estimates for programs were developed by county budget staff and reflect the latest information on the funding levels required for these programs.

The remaining \$9.8 million in the Health Care budget are for programs that the county funded, at some level, in FY 15-16 and for the new initiatives recommended for FY 16-17. There are several areas that should be noted:

- Funding from the Medicaid Low Income Pool (LIP) for Manatee Memorial may provide the County with some flexibility in its 16-17 budget. LIP for Manatee Memorial is funded at \$8.2 million in the Florida General Appropriations Act (GAA) for SFY 16-17 compared to \$1.0 million for SFY 15-16. If this funding occurs at the \$8.2 million level, it may provide the County some flexibility to make some one time investments in health care while Manatee receives this funding from the state in 16-17. The County funding for Manatee Memorial could be reduced for 16-17 but the overall LIP and County funding could still exceed 15-16. The Medicaid match for this \$8.2 million is provided by local governments and it is not anticipated in the GAA that this funding will come from Manatee County. Medicaid match to fund total expenditures in the Florida Medicaid program of \$8.2 million is approximately \$3.3 million. At this time, the local governments have not committed to the funding levels in the GAA for LIP, although Manatee County has received no notification that the Florida Medicaid agency is requesting local funds for the LIP for Manatee Memorial. **It is important to note that the SFY 16-17 is slated to be final year of the Medicaid LIP; therefore, in future years Manatee Memorial, and for that matter all hospitals in Florida, will not receive any LIP funds.**

- Several other adjustments in recommended FY 16-17 funding levels for some programs have been made based upon the actual spending in FY 15-16.
- Funding has been recommended for the new initiatives in FY 16-17 based upon the goals and objectives developed to be presented to the County.

There are two alternative scenarios presented. Alternatives 1 and 2 both provide for the required new initiatives for FY 16-17. Alternative 2 would allow for up to \$1 million to be used for funding for non-recurring initiatives that would not require funding in FY17-18. These would be determined by the County in consultation with the Health Care Advisory Board. Suggested areas for consideration are for one time investments to increase dental capacity for the County program and one time investment in improving housing for indigent residents in the County. Funding for additional initiatives would be available if full LIP funding is provided to Manatee Memorial as proposed in the GAA.

The new initiatives proposed in both Alternatives are:

- \$500K for 5 care managers to assist in coordinating care for the most expensive patients served in the County Health Care program. This is a recurring item.
- \$120K for implementing the care management program. This is a non-recurring item.
- \$50K for evaluating a new Pay for Performance (P4P) approach to reimbursing providers in the County Health Care Program. This is a non-recurring item.
- \$100K to develop a data approach and the metrics for stratifying the highest cost patients that will be participating in the new care management program. This is a non-recurring program.
- \$50K for measuring and evaluating the success of the County Health Care program. This is a recurring item.
- \$50K for a contract grant writer that would assist the County in identifying and applying for any health care grants. It is hoped that the funding for this would be partially funded by non-county sources, such as philanthropy. This is a non-recurring item.
- \$25K for developing a model to more fully integrate behavioral health and primary care. This is a non-recurring item.
- \$50K for an analysis of Arrest Diversion programs for the County to evaluate for implementation in the future. This is a non-recurring item.

The additional item in Alternative 2 is:

- \$1 million for non-recurring initiatives to be determined, as described above.

Assuming that the current level of health care funding can be maintained in FY 16-17, Alternative 1 is easily accomplished and meets the objectives for the recommended changes in FY 16-17. Alternative 2 can be considered if the proposed level of LIP funding in the FY 16-17 GAA materializes and non-recurring initiatives are clearly identified that are determined to provide long-term benefits.

Manatee County Government – Suggested Health Care Programs Budget

	2015-16 Current	2016-17 Alternative 1	2016-17 Alternative 2
Mandates			
Manatee County Health Care Mandates			
1 Jail Medical - F.S. 901.35 and 951.032	\$5,389,431	\$6,089,431	\$6,089,431
2 Health Care Responsibility Act (HCRA) - F.S. 154.301	\$150,000	\$150,000	\$150,000
3 Medicaid Match - F.S. 409.915	\$4,936,695	\$4,911,908	\$4,911,908
4 Forensic Medical Exams for Children - F.S. 39.304	\$69,000	\$69,000	\$69,000
5 Mental Health Transport - F.S. 394.462	\$93,970	\$93,970	\$93,970
Total Mandated Costs	\$10,639,096	\$11,314,309	\$11,314,309
Manatee County Health Department - F.S. 154.001			
6 Manatee County Health Department (Services)	\$929,962	\$929,962	\$929,962
7 Manatee County Health Department (Facility)	\$152,499	\$152,499	\$152,499
Total Manatee County Health Department	\$1,082,461	\$1,082,461	\$1,082,461
Sub- Total Mandates	\$11,721,557	\$12,396,770	\$12,396,770
Other			
Hospital Contracts & Physician Payments			
8 Blake Medical Center*	\$500,000	\$500,000	\$500,000
9 Manatee Memorial & Lakewood Ranch	\$3,525,000	\$3,400,000	\$2,400,000
10 Physician Payments	\$1,303,822	\$1,250,000	\$1,250,000
Total Hospital Contracts & Physician Payments	\$5,328,822	\$5,150,000	\$4,150,000
Health Care Through Clinics (i.e., General, Pharmacy, Specialty Care)			
11 Michael Bach Center	\$41,532	\$0	\$0
12 MCR Health*	\$388,968	\$430,500	\$430,500
13 Prescriptions (County Indigent Prescriptions)	\$200,000	\$100,000	\$100,000
14 Specialty Care (We Care)	\$56,975	\$56,975	\$56,975
15 Pharmaceuticals (We Care)	\$18,000	\$18,000	\$18,000
16 Turning Points - Clinic	\$200,000	\$200,000	\$200,000
Total Health Care Through Clinics, General, Pharmacy & Specialty	\$905,475	\$805,475	\$805,475
Centerstone (formerly Manatee Glens)			
17 Aging Services	\$5,225	\$5,225	\$5,225
18 Baker Act (Adult)	\$709,745	\$709,745	\$709,745
19 Baker Act (Children)**	\$130,441	\$130,441	\$130,441
20 Inpatient/Outpatient Detox	\$811,100	\$811,100	\$811,100
21 Marchman	\$450,000	\$450,000	\$450,000
22 Rape Crisis Child Advocacy Children's Counseling & Kite**	\$99,747	\$99,747	\$99,747
23 Children's Community Action Team**	\$543,916	\$660,916	\$660,916
24 Rape Crisis Adult	\$52,343	\$52,343	\$52,343

		2015-16 Current	2016-17 Alternative 1	2016-17 Alternative 2
	Total Behavioral Health	\$2,802,517	\$2,872,114	\$2,872,114
	Administration			
25	Billing Software	\$150,000	\$50,000	\$50,000
26	Hospital Audits	\$100,000	\$100,000	\$100,000
27	Temp Staff for Eligibility and Billing	\$0	\$20,000	\$20,000
29	HIE Networks - Health Information Exchange	\$8,500	\$0	\$0
	Total Administration	\$258,500	\$170,000	\$170,000
	Pilot Program			
30	Community Para Medicine	\$361,324	\$357,119	\$357,858
31	Diabetes	\$55,000	\$80,191	\$80,191
	Total Pilot Programs	\$416,324	\$437,310	\$438,049
	Reserves for Health Care Programs - TBD			
32	Reserve - Health Care Programs - TBD	\$25,191	\$27,848	\$27,848
33	Reserve - Health Care Programs - Health Care Fund	\$267,536	\$0	\$0
34	Reserve - Health Care Programs - General Fund	\$998,620	\$251,169	\$250,430
	Total Reserves for Health Care Programs	\$1,291,347	\$279,017	\$278,278
	Sub-Total Other	\$11,002,985	\$9,761,319	\$8,761,319
	New Initiatives			
	Care Management Programs (1 Care Manager @ \$100k x 5) - Recurring	\$0	\$500,000	\$500,000
	Care Management Implementation (1 Care Manager @ \$100k x 5) - Recurring	\$0	\$120,000	\$120,000
	Analysis of Conversion to P4P Payment Methodologies	\$0	\$50,000	\$50,000
	Support for Stratification/Analysis of High Cost Patients	\$0	\$100,000	\$100,000
	Measurement of County Health Care Objectives - Recurring	\$0	\$50,000	\$50,000
	Grant Writer (Consultant Federal Grant Writer)	\$0	\$50,000	\$50,000
	Integration of Behavioral Health and Primary Care (Consultant to Assist with Integration Approaches)	\$0	\$25,000	\$25,000
	Analysis of Arrest Diversion Programs	\$0	\$50,000	\$50,000
	Sub-Total New Initiatives	\$0	\$945,000	\$945,000
	Non-Recurring Initiatives (Dental Capacity)	\$0	\$0	\$1,000,000
	Grand Total By Fiscal Year	\$22,724,542	\$23,103,089	\$23,103,089

*Contracts based on HIE participation

**Children's Services Funded

Other Goals and Strategies for Consideration

Goal 3 – Improve access to dental services for low-income uninsured.

Objective 3.1

Improve dental care access for low-income (<200% FPL) uninsured adults as measured by appointment wait times that do not exceed those required in FL Medicaid managed care contracts: Urgent Care — within one (1) day; Routine Sick Patient Care — within one (1) week; Well Care Visit — within one (1) month; and Follow-up dental services — within one (1) month after assessment.

Strategies to consider: Initiate a high-level task force comprised of leadership from Manatee County and with the participation of MCR, Turning Points, LECOM Dental School, the Dental Society, Medicaid Managed Care and Manatee Community Foundation to explore strategies and funding options to improve access. Financial support for dental expansions of existing safety net dental programs; MCR (FQHC) expansion most sustainable. MCR may consider contracting with private providers for FQHC enhanced rate to expand access. Attract dental providers through the Manatee County HPSA shortage area designation for dental provider student loan repayment.

Goal 4 – Improve community awareness of safety net health services and coverage opportunities.

Objective 4.1

Implement a Navigation Center that provides (at minimum) health and human service navigation.

Strategies to consider: Use of/advertising of 2-1-1 of Manasota as navigation center; review and assess 2-1-1 center capabilities and opportunities to expand effectiveness of the health navigation mission. Identify opportunities to disseminate information about and increase understanding of navigation center capabilities throughout the community. 2-1-1 should be provided appointment wait times for primary care, behavioral health and perhaps dental care (see Goals 1 and 2) for more informed referral.

Objective 4.2

Implement a set of outreach programs that provide (at minimum) health and human service navigation.

Strategies to consider: Test/expand paramedicine program focused on health service navigation for high utilizers. Test/expand Community Health Worker Program that focuses on health service navigation and prevention interventions for low-income populations. Explore staffing model(s) including volunteers or health professions students that could serve as navigators. Move toward a common core of outreach worker responsibilities across agencies to include health service navigation, benefits counseling and to the extent possible, incorporating prevention initiatives into the outreach work.

Additional Areas to Explore

Jail Health Services

With a current appropriation of \$5,551,115 for 2016-17 and expected increases next year, Jail Medical services are the most expensive item in Manatee County's health care budget – exceeding payments to hospitals. As a result, the jail should be considered a significant provider for the target population as well as an important component of the overall public health system.

The National Commission on Correctional Health Care, the leading body for health care standards in prisons and jails, emphasizes the importance of viewing the correctional setting as an opportunity to establish better disease control in the community by providing improved health care and disease prevention to inmates before they are released.⁴

Armor Correctional Health Services, Inc. (Armor), the County's vendor for jail health services, should be considered and included when planning for county-wide health care services for the target population. The County should consider a careful review of Armor's contract to identify opportunities to better connect services in jail to the full continuum of care in Manatee County. In particular, the County should give special attention to the following areas:

- Health assessment, including the identification of existing and previous provider relationships for primary care and/or behavioral health
- Appropriate and effective management of chronic conditions and behavioral health conditions
- Administration of public health-focused services prior to release that include:
 - identification and treatment of communicable diseases, including sexually transmitted diseases;
 - identification of pregnancy and initiation of prenatal care;
 - administration of Long-Acting Reversible Contraception for amenable women of child-bearing age;
 - screening and initiation of treatment for behavioral health conditions;
 - access to Vivitrol for appropriate individuals; and
 - immunizations.
- Release planning that includes:
 - connecting individuals to a source of primary care;
 - arranging follow-up care for people with a chronic condition or behavioral health disorder; and
 - information on applying for Medicaid or Exchange coverage.

As the County begins to explore moving to value-based purchasing arrangements with hospitals, MCR, and Centerstone, Armor's approach to payment should also be modified to include payment for its ability to effectively connect individuals being released from the facility in the target population to ongoing sources of care and to employ a care manager as appropriate.

⁴ <http://www.ncchc.org/publications>

Housing

Safe, affordable housing is a primary social determinant of health. It is well-established that people who are homeless or who have unstable housing experience poorer health outcomes. Hospitals and inpatient psychiatric units may find themselves retaining patients longer than is required to treat the individuals' condition due to lack of a safe place for discharge. People with chronic conditions may have difficulty complying with treatment recommendations, even with a source of funding for medication, due to lack of a safe place to store the drugs (e.g., no refrigerator for insulin). Most interviews with Manatee County stakeholders revealed concerns about the availability of affordable housing, even for residents who are not experiencing poverty.

The County has been actively working to address the housing shortage, and in their planning efforts, they should consider housing issues for the target population who are living with chronic conditions or behavioral health disorders. Below are two areas for consideration.

Supported Housing

As defined by the Florida Department of Children and Families, supported housing/living services are designed to help people with substance abuse or psychiatric disabilities find and keep living arrangements of their choice. They also provide services and supports to ensure continued successful living in the community. The goal of Supportive Housing is to ensure that everyone has the opportunity to live as independently as possible.

Although supported housing is a reimbursable service for the target population through state funding administered by the managing entity, the service is not currently available in Manatee County. Residents with serious mental illness who participate with the Florida Assertive Community Treatment team receive housing assistance, but this is the only avenue for housing support and capacity of the program is limited.

The County should consider working with Central Florida Behavioral Health Network to develop the service.

The County may also consider working with Centerstone's Intensive Outpatient Team to create a housing model that includes some county funds for rent payments with support services funded from existing behavioral health services in a wrap-around model.

Non-Traditional Housing Solutions

Communities around the country have been exploring options for providing housing to people who are homeless and who are using a disproportionate amount of health care services, largely through emergency room visits. People without housing may seek care in emergency departments, psychiatric hospitals, or even jails in order to be provided with a meal and a safe place to sleep. The cost of those unnecessary services could be redirected to provide housing.

This strategy is being tested by a partnership between the University of Illinois Hospital & Health Services System and Chicago's Center for Housing and Health. People in the program are given free shelter with no obligation to remain drug free or to become employed, a controversial but likely fiscally

effective approach. The one year pilot program provides \$250,000 to house approximately 20 people. Although data is not yet available on the program, anecdotal results are positive.⁵

A second creative model is operating in California. In Buena Park, the Illumination Foundation, a homeless services nonprofit, converted an abandoned motel to house people who were homeless and needed a place to recover from a health care crisis. A nurse is on staff to supervise the residents' recoveries. The successful pilot was eventually expanded to six sites in four counties: Orange, Los Angeles, Riverside, and San Bernardino.⁶

The County should consider working with the existing housing workgroup, the philanthropy community, hospitals, and behavioral health providers to develop one or more alternative approaches to achieving safe and stable housing for people whose use of health care services appears to be related to issues of homelessness.

⁵ Bayne, M. (2016, April 2). This program could lower health care costs in Chicago. Chicago Business. Retrieved July 19, 2016, from <http://www.chicagobusiness.com/article/20160402/ISSUE01/304029992/this-program-could-lower-health-care-costs-in-chicago?X-IgnoreUserAgent=>

⁶ Gorn, D. (2016, June 29). Old Motels Get New Life Helping Homeless Heal. Kaiser Health News. Retrieved July 19, 2016, from http://khn.org/news/old-motels-get-new-life-helping-homeless-heal/?utm_campaign=KHN:DailyHealthPolicyReport&utm_source=hs_email&utm_medium=email&utm_content=31133755&_hsenc=p2ANqtz--IO6s6TH-gybbZY9PJn2XRYyKN2FA9wBUz-jhb7dkOI-RYVsEnO2BiOptS0pqqdSXJo4S3QLAQWoOAeGOgUidlKaznyq7tBlb2eAWzcfKWMLmmGvg&_hsmi=31133755

Appendix A -- Glossary of Selected Terms

The Health Insurance Marketplace, operated by the federal government in Florida, is where eligible residents can shop for and buy insurance. The Affordable Care Act established the Marketplace (or Health Exchange) to provide a selection of qualified plans for those not eligible for Medicaid, Medicare, TRICARE or an employer-sponsored plan. Individuals/families who buy insurance in the Marketplace may qualify for premium subsidies (tax credits) to help lower the monthly premium.

Primary health care services refer to a basic level of health care that includes health promotion, prevention of disease, early diagnosis of disease or disability, and treatment of disease. Provided in an ambulatory facility, primary health care is a patient's main source for regular medical care, ideally providing continuity (continuous relationship between a provider and patient), and coordination of health care services.

Care management is a team-based, patient-centered approach designed to assist patients and their support systems in managing health conditions more effectively. Typical components are identification of high risk/high utilizers, health risk assessment, development and implementation of a care plan, which would include care coordination, medication review, and self-management approaches needed to help manage chronic illness.

A Chronic disease is a condition lasting 3 months or more; chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear. Examples of chronic diseases include: Diabetes, Congestive Heart Failure, Asthma.

Behavioral health services are services relating to mental health disorders and substance use disorders.

Appendix B: Assessment Deliverables

Appendix B-1. Stakeholder Engagement

The HMA team conducted interviews of multiple key stakeholders including leadership from healthcare and related community organizations, the Manatee County Commissioners, selected Manatee County Healthcare Advisory Board members, and several Manatee County staff. The majority of interviews were conducted individually although a few interviews included multiple individuals from the same organizations. While the majority of interviews were conducted telephonically, several were conducted face-to-face in Manatee County. The following is a list of those stakeholders interviewed as of April 30, 2016.

Planning Committee

The following individuals convened four times during the course of the project to inform and guide approach and recommendations for the Plan. Meetings were held on April 29, June 1, June 21, and August 4.

Dr. William (Bill) Colgate, MCR Health Services

Phil Brown, Director of United Way of Manatee County

Melissa Larkin-Skinner, Centerstone

Dr. Jennifer Bencie, Health Department

Jeannie Slater, Board of Directors for Turning Points

Jacki Dezelski, Chamber of Commerce

Susie Bowie, Executive Director of Manatee Community Foundation

Individual Interviews

Individual interviews were held with the following community leaders during the course of the project. A limited number of additional individuals were targeted for interviews but were unavailable.

Healthcare and Related Community Organizations

Bronwyn Beightol, Senior Vice President

United Way of Manatee County

Jennifer Bencie, MD, Administrator

FL Department of Health in Manatee County

Michele Blackwell, Regional Vice President

Doug Manning, DDS, JD, Regional Executive Director

Mike Carrillo, Regional Director of Provider Engagement
DentaQuest

Phil Brown, President
United Way of Manatee County

Richard Conard, Retired Physician

Ashley Davis, Florida Medicaid Contract Director
Amerigroup

Jacki Dezelski, Executive Vice President
Manatee Chamber Foundation

Kevin Dilallo, CEO
Manatee Memorial Hospital

Adell Erozer, Executive Director
Jill Hinman, Clinical Director
Turning Points

Zach Finn, COO
HIE Networks

Dan Freidrich, CEO
Blake Medical Center

Brandy Hamilton, CEO
Suncoast Behavioral Health

Victoria Kasdan, Executive Director
We Care

Theresa Kelly, Executive Director
Health Council of West Central Florida

Melissa Larkin-Skinner, Chief Clinical Officer
Mary Ruiz, CEO
Centerstone

Linda McKinnon, President and CEO
David Clapp, Community Manager

Central Florida Behavioral Health Network

Don Morgan, Health Services Administrator
Armor Correctional Health Services

Walter "Mickey" Presha, President and CEO
William Colgate, MD, Senior Vice President
Manatee County Rural Health System

Eddie Rodriguez, Assistant Director
Florida Department of Health in Manatee County

Carmen Rojas, CEO
United Way 2-1-1 of Manasota

Chris Russi
United Way 2-1-1 of Manasota

Kersten Schroeder, Director of Community Outreach
Robert George, Dean of Medical School
LECOM

Linda Snyder, Director, Specialized Programs and Contracts
Manatee County Rural Health Services

Valerie Vale, Executive Director
Manatee County Medical Society

Manatee County Commissioners

Vanessa Baugh, Commissioner
Betsy Benac, Commissioner
Larry Bustle, Commissioner
John Chappie, Commissioner
Robin DiSabatino, Commissioner
Charles Smith, Commissioner
Carol Whitmore, Commissioner

Manatee County Community Healthcare Advisory Board Members

Lori Dengler, NP, Member
Ray Fusco, Member
Stephen Hall, Chair
Henry Raines, Member

Tom Skoloda, Member

Dominique Kohlenberger, Member

Philip Brown, Member

Manatee County Employees

Jan Brewer, Director Financial Management

Cheri Coryea, Director, Neighborhood Services

Paul DiCicco, Acting Chief of Emergency Medical Services

Andy Guyre, Human Services Division Manager

Ed Hunzeker, County Administrator

Mary Pendleton-Brown, Fiscal Services Manager

Dan Schlandt, Deputy County Administrator

Kim Stroud, Employee Health Benefits Division Manager

Angela Wilson, Fiscal Specialist

Karen Windon, Deputy County Administrator

Several themes from the interviews and background document review emerged, these included:

- Diversity in perspective on Manatee County's responsibility for healthcare for the uninsured/underinsured.
- Some difficulty for the uninsured in accessing primary care, and even greater limitations in dental and mental health/substance abuse treatment capacity for the uninsured.
- There are significant health care assets in the community (presented later in this document.)
- Data needs to be collected more systematically and used more effectively; there is a need for consensus healthcare metrics.
- The safety net health care system is described as fragmented, lacking coordination of care for the uninsured/underinsured.
- The vision for the "healthcare system" needs to go beyond specific programs to a broader view of health promotion.
- Financial options are currently limited.
- While there seemed to be several coalitions and consortia related to health, action plans on improving access for the uninsured/underserved seemed to be rarely implemented; this may be due in part to a lack of specificity and detailed implementation plan; lack of specific assignments, champions and accountability for implementation; and limited funding to support the identified goals.

Appendix B-2. Community Health Needs Assessment and Asset Inventory

A health care plan for Manatee County uninsured and underinsured must be grounded in healthcare needs and resources, as well as fiscal and political realities. This Community Health Needs Assessment builds upon previously conducted assessments in the County with specific focus on data required to inform such a plan. This includes demographics, core barriers to accessing health care, health indicators, healthcare utilization data, and community health assets.

To conduct this assessment, we collected the most up to date, relevant data available from publicly available sources. We compared this data to Florida overall, the national benchmark which represents the 50th percentile, and the severe benchmark which represents the 75th percentile nationwide. We also collected key utilization data from health care providers in the County. We interviewed multiple stakeholders to add richness to the data.

Demographics

Manatee County is located on Florida's Gulf Coast, bordered by Tampa Bay and St. Petersburg to the North, Hardee and DeSoto Counties to the East, Sarasota County to the South, and the beaches of Anna Maria Island and the Gulf of Mexico to the West. The county seat and the largest municipality in Manatee County is Bradenton. The county has five other municipalities, including the City of Anna Maria, Bradenton Beach, Holmes Beach, the town of Longboat Key, and Palmetto. There are about 334,000 individuals residing in Manatee County, but the population increases considerably in the Winter when "snowbirds" who own or rent homes arrive and spend the Winter in Manatee County (see Table 1 for Manatee County demographics).⁷

⁷ Manatee County CHA and CHIP, 2013

Table 1 Manatee County Demographics⁸

Demographics	Manatee County	Florida
Population, 2012 estimate	333,895	19,317,568
Population, 2010 (April 1) estimates base	322,833	18,802,690
Population, percent change, April 1, 2010 to July 1, 2012	3.4%	2.7%
Population, 2010	322,833	18,801,310
Persons under 5 years, percent, 2011	5.6%	5.6%
Persons under 18 years, percent, 2011	20.4%	21.0%
Persons 65 years and over, percent, 2011	23.7%	17.6%
Female persons, percent, 2011	51.7%	51.1%
White persons, percent, 2011 (a)	86.8%	78.5%
Black persons, percent, 2011 (a)	9.3%	16.5%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.5%
Asian persons, percent, 2011 (a)	1.8%	2.6%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.5%	1.8%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	15.1%	22.9%
White persons not Hispanic, percent, 2011	73.0%	57.5%
Living in same house 1 year & over, percent, 2007-2011	83.4%	83.5%
Foreign born persons, percent, 2007-2011	12.3%	19.2%
Language other than English spoken at home, percentage 5+, 2007-2011	16.3%	27.0%
High school graduate or higher, percent of persons age 25+, 2007-2011	86.7%	85.5%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	26.0%	26.0%
Veterans, 2007-2011	34,437	1,637,466
Mean travel time to work (minutes), workers age 16+, 2007-2011	23.6	25.7
Housing units, 2011	173,660	9,026,965
Homeownership rate, 2007-2011	73.0%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	25.6%	29.9%
Median value of owner-occupied housing units, 2007-2011	\$195,300	\$188,600
Households, 2007-2011	131,318	7,140,096
Persons per household, 2007-2011	2.41	2.56
Per capita money income in the past 12 months (2011 dollars), 2007-2011	\$27,918	\$26,733
Median household income, 2007-2011	\$48,181	\$47,827
Persons below poverty level, percent, 2007-2011	13.6%	14.7%

Using census data for the most recent year available – see table below for 2014 estimates -- there was an estimated 29,931 individuals in Manatee County under 200% of the Federal Poverty Level (FPL that were uninsured. 2014 was also the first year of the federal Health Care Exchange in Florida. In that year, Manatee County had an enrollment in the exchange of approximately 12,223 of which it is estimated that 7,850 of those individuals were under 200% of poverty.

While the census data for the number of uninsured for 2014 is reflective of sampling that occurred in 2014 it is unlikely that those numbers are fully reflective of the individuals enrolled in the exchange at that time. Given the individuals eligible who have already gotten coverage through a health insurance

⁸ IBID

exchange, and understanding there is some margin for error, we estimate that there are currently approximately 25,000 uninsured individuals under 200% of the FPL in Manatee County at present.

**Table 2 - Manatee County
Health Insurance Coverage Status By Income
2014 American Community Survey 1-Year Estimates**

Under 138% FPL					
	<18 years	18 - 64 years	65 + over	Total	Percent
Insured	20,863	21,130	12,490	54,483	
Uninsured	840	16,361	197	17,398	32.94%
Sub-Total	21,703	37,491	12,687	71,881	
138% to 199% FPL					
	<18 years	18 - 64 years	65 + over	Total	Percent
Insured	8,237	15,229	11,285	34,751	
Uninsured	1,395	10,438	0	11,833	22.40%
Sub-Total	9,632	25,667	11,285	46,584	
200% to 399% FPL					
	<18 years	18 - 64 years	65 + over	Total	Percent
Insured	16,216	42,005	28,647	86,868	
Uninsured	2,010	14,813	140	16,963	32.11%
Sub-Total	18,226	56,818	28,787	103,831	
400% FPL and Over					
	<18 years	18 - 64 years	65 + over	Total	Percent
Insured	16,536	65,667	36,367	118,570	
Uninsured	824	5,731	71	6,626	12.54%
Sub-Total	17,360	71,398	36,438	125,196	
Total ALL					
	<18 years	18 - 64 years	65 + over	Total	Percent
Insured	61,852	144,031	88,789	294,672	84.80%
Uninsured	5,069	47,343	408	52,820	15.20%
Sub-Total	66,921	191,374	89,197	347,492	

Source:

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_C27016&prodType=table

Data Related to Core Barriers to Accessing Care

Table 3 below shows indicators related to core barriers to accessing care. Manatee County has a significantly higher ratio of individuals per primary care physician (2,504) than Florida (1,309) and the national benchmark (1,641) indicating a primary care physician shortage. The percent of the population at or below 200% FPL is approximately the same in Manatee County (36.31%) as the national benchmark (36.6%), and slightly lower than Florida (38.1%). The percent of the population uninsured is higher in Manatee County (18.03%) than the national benchmark (14.10%), and slightly lower than Florida (19.6%). Lastly, the percent of adults (18+ years old) that could not see a doctor in the past year due to cost (16.0%) was higher than the national benchmark (13.4%) and comparable with Florida (16.0%).

Table 3 Core Barriers to Accessing Care

Core Barriers to Accessing Care	Manatee County	Florida	National Benchmark ⁹
Population to 1 FTE Primary Care Physician ¹⁰	<u>2504</u>	1,390	1,641
Percent at or below 200% FPL ¹¹	36.31%	38.1%	36.60%
Percent of Population Uninsured ¹²	<u>18.03%</u>	19.6%	14.10%
Percent of adults (18+ years old) that could not see a doctor in the past year due to cost ¹³	<u>16.0%</u>	16.0%	13.4%

The data in Table 3 indicates limited primary care physician capacity, a sizable proportion of the population below 200% of poverty, a high uninsured rate and a high rate of surveyed adults indicating that they were unable to see a doctor in the past year due to cost. The uninsured rate in Table 3 represents the total civilian non-institutionalized population of all ages as a 5 year average up to and including 2014. The uninsured rate in Table 2 is lower as it represents the rate for the year 2014 only.

The median monthly Medicaid enrollment rate in Manatee County was 24,699 per 100,000 people, lower than the rate across Florida at 29,307 per 100,000 people.¹⁴

A 2015 Manatee County Community Health Survey, facilitated by the Wellness Committee, Manatee Health Care Alliance, validated the data above. The survey results confirmed that barriers to healthcare in Manatee County included cost, not having health insurance, not being able to find a doctor that takes their insurance, being unable to get an appointment, not knowing where to go, and not having a way to get to the doctor.

These findings speak to the capacity of health care services for the low-income uninsured and underinsured, as well as to issues related to navigating healthcare and enabling services.

⁹ National benchmark is defined by the 50th percentile/median rate based on national data.

¹⁰ HRSA HPSA Designations Combined with Dartmouth Primary Care Provider Data, 2014

¹¹ US Census American Community Survey, 2014

¹² US Census American Community Survey, 2014

¹³ County Health Rankings, 2013

¹⁴ Agency for Health Care Administration, 2013-2015 Three Year Rolling Rates

While determining the capacity and specific needs based on the population is beyond the scope of HMA's contract, the following provides some indication of issues related to capacity and demand.

Primary Care Service Access

The population to primary care physician ratio in Manatee County represents a severe physician shortage. Manatee County Rural (MCR) Health System – a large Federally Qualified Health Center in the County – has indicated in their most recent data, that they care for approximately 42% of the uninsured in the County.¹⁵ MCR conducts a “secret shopper” assessment regularly of all its sites to determine wait times for getting an appointment; this data has been requested but not yet received. Based on interviews with organizations in the community that refer uninsured individuals to MCR, there appears to be limited capacity in that system for new patients.

Other safety net primary care practices, for example, Turning Points and We Care Manatee, are comprised of some paid, but mostly of volunteer providers and have limitations in capacity. We understand that private providers accept a limited number of uninsured and Medicaid patients but were unable to find data to substantiate the numbers.

Evidence suggests that high-quality outpatient care can prevent hospital emergency department visits and admissions for Ambulatory Care Sensitive Conditions. In 2014, Ambulatory Care Sensitive Condition visits from Manatee County uninsured persons to Manatee Memorial Hospital was 28,600 representing 21% of all emergency department (ED) visits and \$312M in estimated costs.

Manatee Memorial Hospital ED visits went from 74K to 77,000 visits from 2014 to 2015. Of the total ED visits in 2015, 15% were uninsured and 38% Medicaid-covered. More than half (53%) of the ED visits at this hospital were made by uninsured and Medicaid in 2015. For the same year, uninsured inpatients represented 8% of census, and Medicaid-covered individuals represented 17% of census, only 25% of the admissions.¹⁶ This implies an overuse of the ED for these individuals; more individuals would have been admitted if more ED encounters were true emergencies.

Primary care capacity appears to be less than sufficient to meet the needs of the uninsured and underinsured in the County.

Mental Health Service Access

Centerstone (formerly Manatee Glens Mental Health Center) offers mental health and addictions care and treatment to Manatee County residents. It offers a range of treatment, support and educational programs and services to individuals who have mental health and addiction disorders and adults with intellectual and developmental disabilities.

¹⁵ From an interview with Dr. William Colgate; updated data has been requested, not yet shared. March 2016.

¹⁶ From a presentation at Manatee Memorial Hospital for HMA; validation of data has been requested, not yet shared. March 2016.

While individuals can get an evaluation immediately at Centerstone's Walk-in Center or Access Center, wait times for a psychiatrist or nurse practitioner vary from 1 - 2 months depending on location, and therapy is 7 days - 1 month depending on location.

Suncoast Behavioral Health Center is a 60-bed private, acute inpatient psychiatric facility designed for children, adolescents and adults.

Behavioral health capacity is less than sufficient to meet the needs of the uninsured and underinsured in the County, particularly for substance use disorder treatment. Additional capacity is being developed at Centerstone, but Manatee county residents in need of care are sometimes sent to Sarasota county due to lack of beds. The rapid rise of opioid addiction has been a contributing factor.

Oral Health Service Access

A recent study published in the *Journal of Public Health Dentistry*¹⁷ found the number of dental-related visits to Florida emergency departments surged from 104,642 in 2005 to 163,900 in 2014, an increase of about 57 percent. The total charges over that period increased more than threefold, reaching \$193.4 million in 2014. Forty percent of the Florida patients who sought dental-related care in an emergency room in 2014 were covered under Medicaid. Finding a provider can be difficult; only about 860 dentists, or about 8 percent of professionally active dentists statewide, participate in the Medicaid program. Another 38 percent of visits were by people who did not have medical insurance and paid out of pocket, and 11 percent were commercially insured.

Manatee County Rural Health System has two dental clinics with a total of 5 dentists and 2 dental hygienists who appear to be scheduled to capacity. According to leadership at the MCR, wait lists for adult dental visits are long. The perception from other providers in the community is that MCR "is closed to new adult patients for dental services." Like primary care, other safety net dental practices, such as Turning Points, are very limited in size. They are currently building out dental operatories and will have 3 full service rooms and a hygiene room, and are staffed with three part-time paid dentists, two volunteer dentists, and a paid hygienist. Turning Points receives approximately 10 telephone calls per day for dental services that they are unable to meet with nowhere to refer them but a hospital emergency department. We understand that private providers accept a limited number of uninsured and Medicaid patients.

Dental capacity is clearly less than sufficient to meet the needs of the uninsured and underinsured in the County.

¹⁷ <http://www.tampabay.com/news/health/dental-care-in-the-er-is-costing-us-millions-8212-and-not-helping-patients/2276147>

Health Status Indicators

Diabetes and Obesity

Table 4 below shows health indicators related to diabetes and obesity. The data reveals that Manatee County (10.2%) surpasses the severe benchmark (9.2%) in the prevalence of diabetes. Despite this, the diabetes mortality rates is lower in the County (11.9), than Florida (12.3) as well as the national (22.5) and severe (24.8) benchmarks. Manatee County rate of obesity (24.6%) is lower than the national benchmark (27.6%) and Florida (25.2%). Notably, this may be reflective of the high physical activity rate of adults in Manatee County: 9 in 10 people (90%) are physically active in Manatee County, compared to 1 in 4 people (25%) in Florida.

Table 4 Health Indicators Related to Diabetes and Obesity

Health Indicators Related to Diabetes and Obesity	Manatee County	Florida	National Benchmark	Severe Benchmark ¹⁸
Age-Adjusted Diabetes Prevalence ¹⁹	10.2%	10.4%	8.1%	9.2%
Adult Obesity Prevalence ²⁰	24.6%	25.2%	27.6%	30.2%
Age-Adjusted Diabetes Mortality Rate ²¹	11.9	12.3	22.5	24.8
Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test ²²	13.2%	15.0%	18.0%	20.4%
Percent of adults (18 years and older) with no physical activity in the past month ²³	10.2%	24.0%	24.0%	26.6%

Cardiovascular Disease

Table 5 below shows health indicators related to cardiovascular disease. In Manatee County, there is low mortality due to heart disease (138.9) compared to Florida (151.3) and the national (179.4) and severe (203.4) benchmarks. However, the proportion of adults reporting diagnosis of high blood pressure in Manatee County (34.5%) is comparable to Florida (34.2%) but surpasses both the national (28.7%) and severe (31.4%) benchmarks. The percent of adults who have not had their blood cholesterol checked within the last 5 years is 19.9% in Manatee County, lower than Florida (21.0%) and both the national (23.1%) and severe (25.7%) benchmarks. Overall, heart disease is down 22% (2005 to 2014) in Manatee County, showing a similar trend experienced throughout Florida.²⁴

¹⁸ Severe bench mark is defined by the 75th percentile/median rate based on national data.

¹⁹ BRFSS, 2010

²⁰ BRFSS, 2012

²¹ CDC WONDER, 2014

²² Dartmouth Atlas of Health Care, 2012; Statewide data from County Health Rankings, 2014

²³ CDC Diabetes Interactive Atlas, 2012; Statewide data from County Health Rankings, 2014

²⁴ Florida CHARTS 2014, as reporting in the Manatee CHA July 2015.

Table 5 Health Indicators Related to Cardiovascular Disease

Health Indicators Related to Cardiovascular Disease	Manatee County	Florida	National Benchmark	Severe Benchmark
Age-Adjusted Mortality from Diseases of the Heart ²⁵	138.9	151.3	179.4	203.4
Proportion of Adults reporting diagnosis of high blood pressure ²⁶	<u>34.5%</u>	34.2%	28.7%	31.4%
Percent of adults who have not had their blood cholesterol checked within the last 5 years ²⁷	19.9%	21.0%	23.1%	25.7%
Age-adjusted cerebrovascular disease mortality (per 100,000) ²⁸	24.8	33.0	41.4	46.3

Cancer

Table 6 below shows health indicators related to cancer. In Manatee County, one in four women 18 and older did not receive a pap test in the past 3 years (25.1%), similar to Florida (24.7%) but higher than the national (18.4%) and severe (20.1%) benchmarks at approximately 1 in 5 women. Cancer screening rates are low in Manatee County. For breast cancer, Manatee County (27.4%) surpasses the national (22.2%) and severe (25.8%) benchmarks, and is similar to Florida (24.7%). For colorectal screening, more adults (50 and older) are getting screened in Manatee County; however, nearly 8 in 10 age appropriate adults are still not receiving screening in Manatee. Table 5 also shows that more adults smoke cigarettes in Manatee County (18.3%) than in Florida (17.7%), surpassing the national benchmark (17.3%).²⁹ Overall, cancer mortality rate for both breast (9.5) and colorectal (13.0) cancers is lower than Florida, and below the national and severe benchmarks for both cancers. Overall, mortality due to cancer is down 12% (2005 to 2014) in Manatee County, showing a similar trend experience throughout Florida.³⁰ Related, the cancer rates among Manatee County residents is 147 per 100,000, lower than Florida at 160 per 100,000.³¹

Table 6 Health Indicators Related to Cancer

Health Indicators Related to Cancer	Manatee County	Florida	National Benchmark	Severe Benchmark
Cancer Screening -- Percent of women 18 and older with No Pap test in past 3 years ³²	<u>25.1%</u>	24.7%	18.4%	20.1%

²⁵ CDC Wonder, 2014

²⁶ BRFSS, 2011

²⁷ BRFSS, 2011

²⁸ CDC Wonder, 2014

²⁹ 2013 BRFSS Survey and 2014 Youth Tobacco Survey data indicates that rates of tobacco use among adults and youth 11-17 years of age increased in Manatee County between 2007 and 2013. Similar trend was identified in Florida. As reported in Manatee CHA July 2015.

³⁰ Florida CHARTS 2014, as reported in the Manatee CHA July 2015.

³¹ Ibid.

³² BRFSS, 2012

Cancer Screening -- Percent of women 40 and older with No Mammogram in past 2 years³³	<u>27.4%</u>	27.5%	22.2%	25.8%
Cancer Screening -- Percent of adult 50 and older with No Fecal Occult Blood Test within the past 2 years³⁴	79.7%	79.6%	83.3%	85.0%
Percent of adults who currently smoke cigarettes³⁵	<u>18.3%</u>	17.7%	17.3%	20.3%
Age-adjusted colorectal cancer mortality³⁶	13.0	13.3	14.0	15.2
Age-adjusted breast cancer mortality³⁷	9.5	10.7	22.1	23.8

Child Health

Table 7 below shows health indicators related to child health. In Manatee County, the percent of children (19 - 35 months) not receiving recommended immunizations is 27.3%, the same as throughout Florida (27.3%), and lower than the national (30.0%) and severe (34.6%) benchmarks. Compared to the national (84.1%) and severe (89.3%) benchmarks, the percent of children not tested for elevated blood levels by 72 months of age is very low (11%), indicating that 9 in 10 children are receiving these tests. The data also show that the percent of children (0-17 years) who are obese is 14.7% in Manatee County, slightly lower than Florida (15.7%) and below the national (15.0%) and severe (18.1%) benchmarks. In comparison to Florida, Manatee County is doing better than other counties in Florida in some of these indicators. For example, Manatee County is in second quartile (better than Florida average) in fully immunize kindergarten children.³⁸

Table 7 Health Indicators Related to Child Health

Health Indicators Related to Child Health	Manatee County	Florida	National Benchmark	Severe Benchmark
Percent of children (19-35 months) not receiving recommended immunizations 4-3-1-3-3-1-4³⁹	27.3%	27.3%	30.0%	34.6%
Percent of Children not tested for elevated blood lead levels by 72 months of age⁴⁰	11.0%	12.4%	84.1%	89.3%
Percent of children (10-17 years) who are obese⁴¹	14.7%	15.7%	15.0%	18.1%

³³ BRFSS, 2012

³⁴ BRFSS, 2012

³⁵ BRFSS, 2012

³⁶ CDC Wonder, 2014

³⁷ CDC Wonder, 2014

³⁸ Florida CHARTS 2014, as reported in the Manatee CHA July 2015.

³⁹ CDC NIS, 2014

⁴⁰ CDC Lead Poisoning Branch, 2009

⁴¹ Child Health Data, 2012.

Perinatal and Prenatal Health

Table 8 below shows health indicators related to perinatal and prenatal health. Notably, in Manatee county, late entry into prenatal care occurs in over 1 in 4 of all birth (28.2%), surpassing the national (16.4%) and severe (21.1%) benchmarks. The percent of births to teenage mothers (15-19 years) (8.5%) is just slightly higher than the national benchmark (8.4%) in the county. Infant mortality rate (6.98) and low birth weight rate (8.0) also both pass the national and severe benchmarks for both indicators in Manatee County.

Table 8 Health Indicators Related to Perinatal and Prenatal Health

Perinatal and Prenatal Health	Manatee County	National Benchmark	Severe Benchmark
Low Birth Weight Rate, 5 year average ⁴²	<u>8.0%</u>	7.90%	9.40%
Infant Mortality Rate, 5 year average ⁴³	<u>6.98</u>	6.6	7.9
Births to Teenage Mothers (15-19) (Percent of all births) ⁴⁴	<u>8.5%</u>	8.40%	10.00%
Late entry into prenatal care (entry after first trimester) (Percent of all births) ⁴⁵	<u>28.2%</u>	16.4%	21.1%
Cigarette use during pregnancy (Percent of all pregnancies) ⁴⁶	9.5%	14.10%	18.20%
Percent of births that are preterm (<37 weeks gestational age) ⁴⁷	8.6%	12.0%	13.0%

In comparison to Florida, Manatee County is doing better than other counties in Florida in some of these indicators. For example, Manatee County is in second quartile (better than Florida average) in mothers smoking during pregnancy, low birth weight, and preterm births.⁴⁸ However, for others, Manatee County is worse than the Florida average. For example, Manatee County is in the third quartile for births to mothers 15-19 years and infant mortality. In the fourth, least favorable, quartile among Florida Counties, Manatee County unfavorable rates in births with first trimester prenatal care, births with late or no prenatal care, births to uninsured women, repeat births to mothers 15-19 years of age, and births with inter-pregnancy interval less than 18 months.⁴⁹

⁴² County Health Rankings, 2014.

⁴³ CDC WONDER, 2013.

⁴⁴ CDC WONDER, 2014.

⁴⁵ CDC WONDER, 2014.

⁴⁶ CDC WONDER, 2014.

⁴⁷ CDC WONDER, 2014.

⁴⁸ Florida CHARTS 2014, as reporting in the Manatee CHA July 2015.

⁴⁹ Florida CHARTS 2014, as reported in the Manatee CHA July 2015.

Behavioral Health

Table 9 below shows health indicators related to behavioral health. The suicide rate is higher in Manatee County (15.3) than Florida (13.9), and just surpasses the severe benchmark (15.2). This represents an overall increase since 2005, in that deaths due to suicide are up 37% in Manatee County, while Florida rates remained steady.⁵⁰ The death rate due to suicide is high in Manatee County at 15.3 per 100,000 people which is comparable to the severe national benchmark of 15.2. Mortality to drug overdose in Manatee County (30.9) is twice as high the severe benchmark (14.8), and nearly two times higher than the rate throughout Florida (13.2). Nearly 3 in 50 adults (5.8%) in Manatee County experience at least one major depressive episode in the past year, similar to Florida (5.8%) and below the national (6.6%) and severe (7.3%) benchmarks. Binge alcohol use among people 12 and over is at 20.9% in Manatee County, also similar to Florida (20.9%) and below the national (24.1%) and severe (26.1%) benchmarks.

Table 9 Health Indicators Related to Behavioral Health

Health Indicators Related to Behavioral Health	Manatee County	Florida	National Benchmark	Severe Benchmark
Percent of adults with at least one major depressive episode in the past year ⁵¹	5.8%	5.8%	6.6%	7.3%
Suicide Rate ⁵²	<u>15.3</u>	13.9	13.5	15.2
Binge alcohol use (Percent among population 12 and over) ⁵³	20.9%	20.9%	24.1%	26.1%
Age-adjusted drug poisoning (i.e. overdose) mortality rate per 100,000 population ⁵⁴	<u>30.9</u>	13.2	12.3	14.8

Compared to Florida, Manatee County adults self-report better mental health versus the state average. Somewhat poorer mental health was reported among middle-aged adults, women, and those in the lowest income category.⁵⁵ Trends in Mental Health and Substance use is showing a short-term downward trend between 2010 and 2012 in unintentional poisoning deaths (including drug overdoses), while in the long-term, these rates have been increasing to above the state average between 1994 and 2013.⁵⁶

Other Health Indicators

Table 10 below show various other health indicators, particularly those where the prevalence in Manatee County surpasses Florida and/or national benchmarks. Of note, the percent elderly (65 and older) in Manatee County (24.3%) surpasses Florida (18.2%) and the national benchmark (15.2%).

⁵⁰ Florida CHARTS 2014, as reported in the Manatee CHA July 2015.

⁵¹ SAMHSA National Survey on Drug Use and Health, 2014.

⁵² CDC WONDER, 2014.

⁵³ SAMHSA National Survey on Drug Use and Health, 2014.

⁵⁴ CDC WONDER, 2014.

⁵⁵ 2013 BRFSS Survey, as reported in the Manatee CHA July 2015.

⁵⁶ Florida CHARTS 2014, as reported in the Manatee CHA July 2015.

Nearly half (43.6%) of these adults 65 years and older have not had a flu shot in the past year. Additionally, the age-adjusted unintentional injury death rate in Manatee County (61.7) is higher than both the Florida (41.4) and national benchmark (40.0).

“Linguistic isolation” is defined by the U.S. Census Bureau as all members of a household 14 years old and over having at least some difficulty with English. There is a large percentage of the population in Manatee County that are linguistically isolated (17.9%) compared to the national benchmark (10.3%). Additionally, oral health is lacking among population as indicated by the 38.9% of people without a dental visit in the last year, significantly higher than the national benchmark (30.4%).

Table 10 Other Health Indicators

Other Health Indicators	Manatee County	Florida	National Benchmark
Age-Adjusted Death Rate (per 100,000) ⁵⁷	618.6	662.0	764.8
HIV Infection Prevalence ⁵⁸	<u>0.5%</u>	0.6%	0.2%
Percent Elderly (65 and older) ⁵⁹	<u>24.3%</u>	18.2%	15.2%
Three Year Average Influenza and Pneumonia Death Rate (per 100,000) ⁶⁰	5.1	9.2	18.6
Adult Current Asthma Prevalence ⁶¹	<u>8.5%</u>	8.3%	9.0%
Age-adjusted Unintentional Injury Death Rate ⁶²	<u>61.7</u>	41.4	40.0
Percent of population linguistically isolated (percent of people 5 years and over who speak a language other than English at home) ⁶³	<u>17.9%</u>	27.8%	10.3%
Percentage of adults 65 years and older who have not had a flu shot in the past year ⁶⁴	<u>43.6%</u>	45.3%	32.6%
Chlamydia (sexually transmitted infection) rate (per 100,000) ⁶⁵	<u>430.6</u>	430.6	389.5
Oral Health (Percent without dental visit in last year) ⁶⁶	<u>38.9%</u>	40.2%	30.4%

Summary

Overall, there are several health indicators that are of particular concern; indicators that are above the 75th percentile nation-wide, representing what the federal government refers to as the “severe

⁵⁷ CDC WONDER, 2014.

⁵⁸ CDC, 2013.

⁵⁹ US Census American Community Survey, 2014.

⁶⁰ CDC WONDER, 2014.

⁶¹ BRFSS, 2010.

⁶² CDC WONDER, 2014.

⁶³ US Census American Community Survey, 2014.

⁶⁴ BRFSS, 2012.

⁶⁵ CDC, 2014.

⁶⁶ BRFSS, 2012.

benchmark.” These areas should be strongly considered when planning health and healthcare interventions in Manatee County. Of those health indicators measured, the following exceed the severe benchmark: diabetes prevalence, diagnosis of high blood pressure, cervical and breast cancer screening, late entry into prenatal care, rates of suicide and drug overdose.

Additional health indicators that exceed the national benchmark, and should also be considered for intervention, include rates of cigarette smoking, low birth weight, infant mortality rate, birth to teen mothers, prevalence of HIV and sexually transmitted infection, unintentional injury, and percent of older adults without an influenza vaccine.

Another very significant concern is oral health – the percent of adults without dental visit in the last year. While the percent for Manatee County is on par with Statewide rates, it is significantly higher than the national average.

Appendix B-3. Selected Assets Available to Address Health Issues

Manatee County has several assets and resources that can be mobilized to address community health issues.

- The Manatee Healthcare Alliance, Inc. was formed in 2010 to identify and address health issues and priorities in the County. The Alliance is led by a community healthcare advocate, Manatee County Government, the Manatee County Chamber of Commerce, and Florida Department of Health in Manatee, includes representatives from all sectors within the community. The Alliance adopted a strategic plan in August 2012 which included two strategic priorities:
 - #1: Create a sustainable patient-centered model for a Manatee County health care program that will demonstrate cost-effectiveness and improved outcomes.
 - #2: Begin at least one community health care campaign that engages the Manatee County community in addressing an important health factor such as: physical activity, good nutrition, tobacco cessation, preventive health screenings.
- Manatee County also participates in a variety of regional health assessment and planning partnerships.
- Manatee County Rural Health Services (MCR) is the largest federally qualified healthcare center in the Southeast, providing primary care access to residents. MCRH has 14 locations in the County providing primary care, medical sub-specialties, behavioral health and dental services.
- The county has twenty EMS units with an average response time of 6.05 minutes.
- There are community organizations that facilitate healthcare access and provide resources. For example, 2-1-1 is staffed 24/7 to provide resource and referral in health and human services, and hosts an electronic resource database for use by anyone with web access. Other non-profit organizations work to fill gaps in care for low-income, uninsured, for example: Turning Points provides free primary care and dental care, and We Care Manatee facilitates the provision of free primary and specialty care through volunteerism.
- Centerstone offers mental health and addictions care and treatment to Manatee County residents. Suncoast Behavioral Health Center is a private, acute inpatient psychiatric facility for children, adolescents and adults.
- There are three major hospitals within the county: Blake Medical Center, Lakewood Ranch Medical Center, and Manatee Memorial Hospital. Centerstone provides psychiatric, mental health and substance abuse services on an inpatient and outpatient basis.
- The County subsidizes private physicians participating in the County's program for the cost of medically necessary health care services for low-income uninsured residents meeting eligibility criteria. This funding is capped at \$1,250,000 for FY 2016. Hospitals and other health care programs in the community are funded separately.

- Manatee County is also the home of the LECOM College of Osteopathic Medicine, School of Pharmacy and School of Dentistry. The Colleges have a variety of local community service programs and community-based rotations for their medical and pharmacy students, but not dental students. The dental school operates a dental clinic on campus but there are substantial charges for care.
- The Florida Department of Health in Manatee County is a great asset; it was identified in 2010 by the CDC as an ACHIEVE community (Action Communities for Health, Innovation and EnVironmental ChangE). The ACHIEVE initiative is designed to shift communities from individual and program-based public health to a broader focus on policy, environmental and systems change to promote wellness and reduce risk factors for chronic diseases, including obesity and tobacco use.⁶⁷

⁶⁷ Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) 2013

Appendix B-4. Environmental Scan: Selected National Programs to Inform a Manatee County Healthcare System for Vulnerable Populations

1-Coverage Programs for the Uninsured/Underinsured

Central Health, Medical Access Program. Travis County, TX

- Central Health is the local public entity that connects low-income Travis County residents to health care and operates the Medical Access Program (MAP) for residents at or below 100% Federal Poverty Income Guideline; elderly or disabled residents must be at or below 200% FPIG.
- MAP is not a health insurance plan, it is a local program that covers primary care, prescriptions, specialty care and hospital care. Providers apply to enroll in the MAP provider network and are paid by Central Health to care for MAP enrolled patients. The MAP program is capped at around 25,000 patients in the County.
- As the taxing entity for Travis County, the Travis County Commissioners Court provides Central Health with its budget to subsidize MAP providers.

<http://www.centralhealth.net/>

Project Access, Buncombe County Medical Society. Buncombe County, NC

- Physician volunteer initiative providing access to comprehensive medical care for low-income uninsured County residents since 1996. More than 2,500 low income residents receive healthcare through the Project annually.
- A network of more than 500 physicians in the County along with a hospital, local pharmacies, mental health providers, community service navigators and others provide healthcare without reimbursement. Certified Health Access Counselors assist patients in understanding healthcare options – including enrollment in the health insurance marketplace.
- Sponsored by a County Medical Society, Project operations are supported by donations from businesses and individuals in the community.

<http://www.mywcms.org/philanthropy/health-access-priority/project-access>

County Programs for the Medically Indigent in California. All California Counties

- By law, California's counties are the health care providers of last resort for residents age 18 and older who cannot afford care.
- Approximately 34 Counties have the authority to contract out for the administration of their coverage program, which is a uniform set of benefits similar to Medi-Cal. Approximately 24 counties manage their own programs, setting their own rules about services and eligibility.
- The California Healthcare Foundation developed fact sheets and data profiles for all 58 California county coverage programs describing their approaches to providing care for this population.

<http://www.chcf.org/publications/2009/10/county-programs-for-the-medically-indigent-in-california>

Hillsborough Health Care Plan. Hillsborough County, FL

- Funded by a ½ cent sales tax, Hillsborough County provides a comprehensive managed care program for County residents with limited income and assets who do not qualify for other health care coverage, including Medicare and Medicaid.
- The Plan provides primary and specialty care, inpatient and outpatient treatment, pharmaceuticals, and other “medically necessary” services through contractual relationships.
- Members are assigned a Primary Care Physician (PCP) at a participating clinic that serves as the members’ Medical Home. The PCP provides specialty and other referrals and coordinates care.

<http://www.hillsboroughcounty.org/index.aspx?NID=864>

2-Appropriate Utilization of Hospital/Emergency Department

Medical Home Network. Chicago, IL

- An Accountable Care Organization focused on residents with Medicaid coverage on the South Side of Chicago, Medical Home Network (MHN) built an innovative web-based portal to enhance care coordination between disparate entities serving the same patients.
- Recognizing that a primary care practice needs to continually receive up-to-date information about the health care utilization of its patients to improve the health status of residents and reduce health care costs for vulnerable populations in the region, the MHN portal provides:
 - Real-time hospital utilization alerts to primary care practices
 - Medicaid claims data including filled prescription data
 - Condition tagging
 - Demographic data
 - Medical home assignment
- Primary care practices work with hospitals to divert patients from unnecessary hospital admissions, and provide transition care and timely follow-up appointments

<http://www.mhnchicago.org/index.html>

http://articles.chicagotribune.com/2012-04-20/business/ct-biz-0417-medical-home-network-20120420_1_medical-home-network-primary-care-clinics-and-physician-practices

Community Paramedicine

- Community paramedicine programs have been designed to address the needs of isolated persons who need outreach. Though initially started in rural areas, the concept has been expanded to meet the needs of many isolated individuals whose medical needs can be better met outside of emergency medical services and emergency rooms. [Manatee County is about to initiate such a program.]

<http://communityparamedic.org/>

Camden Coalition of Health Care Providers

- Innovative work in “hot-spotting” or identifying high utilizers of health care services and designing interventions to direct services to better meet these clients’ needs.

<http://www.chcs.org/hotspotting-driver-behind-camden-coalitions-innovations/>

<http://healthcarehotspotting.com/wp/introduction/>

3- Appropriate Utilization of Specialty Care

Cook County Internet Referral Information System (IRIS). Chicago/Cook County, IL

- Cook County Health and Hospital System developed a nationally-recognized, web-based system for primary care providers to request referrals to specialty care and diagnostics.
- A software program applies evidence-based rules to approve, expedite, or deny specialty referrals. A total of twenty-two percent of referrals were screened out as inappropriate during the first year of operation, dramatically decreasing wasted specialty visits. Denials can be appealed for clinical review.
- Referrals are tracked electronically, allowing assessment of demand, wait times, and other measures useful for evaluation and planning. Referral processing time was reduced from an average of 3 months to 5.5 days compared to the previous manual system.

<http://content.healthaffairs.org/content/29/5/972.full.html>

http://www.improvingchroniccare.org/index.php?p=Humboldt_County&s=346

University of California at San Francisco (UCSF) E-Consult. San Francisco, CA

- eConsult at UCSF is a mechanism whereby primary care providers request and receive an electronic subspecialty consultation within 72 hours for patients that do not require an in-person evaluation.
- This innovation allows for rapid access to subspecialist expertise for appropriate questions, improves access to scarce subspecialty visits by reducing visit demand, and has been demonstrated to save patients time and money.

https://medicine.ucsf.edu/care/amb_committee.html

https://medicine.ucsf.edu/care/erefferal_newsletter.pdf

4- Behavioral Health Interventions

IMPACT Model: Integrating Depression Care into Primary Care

- The Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) is a collaborative model to systematically identify and treat individuals with depression in the primary care practice. The model features medication management with psychiatry back-up and/or short-term therapy by a psychologist or clinical social worker, and depression care management.

- Largest randomized controlled trial undertaken for a depression intervention reported that the program was substantially more effective than usual care in reducing depression and improving physical and social function even at the 24-month follow-up, 12 months after the end of the program.

<http://impact-uw.org/>

Jail Diversion Program for Persons with Serious Mental Illness. Bexar County, TX

- Bexar County's national model for jail diversion is structured to offer guidance for individuals with Serious Mental Illness (SMI) when they are at an early stage in the criminal justice system process under the premise that "early diversion helps prevent today's misdemeanants from becoming tomorrow's felons."
- The jail diversion partnership involves multiple levels of government, law enforcement and the courts. Efforts include but are not limited to the following: consolidation of the City/County crisis services, establishment of mobile crisis teams, training of dispatchers and police officers in crisis intervention and to recognition of SMI to help ensure an appropriate response. Mental health services collaborate with hospitals to provide care for diverted individuals with SMI. Advocacy programs help consumers make their way through the legal process toward treatment.
- Results include significant decrease in ER utilization of individuals with SMI and significant reductions of jail admissions for misdemeanors.

<http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf>

5-Expanding Dental Capacity

- FQHCs are typically the most viable option for providing dental services for Medicaid and low-income uninsured individuals due to their enhanced reimbursement rates and grant to subsidize low-income, uninsured patients. Expanding dental capacity requires an investment to build out and equip operatories.
- A low-cost option available to FQHCs for expanding access to dental services is to contract with private providers for an enhanced reimbursement rate. In 2009, the U.S. Congress determined that FQHCs may contract with private dentists to provide dental services to health center patients in the dentists' private offices for the enhanced rate.
- The Children's Dental Health Project developed an implementation handbook for FQHCs interested in this approach (link below.) A taped webinar by The Lakes Community Health Center, a Wisconsin FQHC, presents experience contracting with private providers (link below.)

Children's Dental Health Project. "Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers." 2011.

<https://www.cdhp.org/resources/243-fqhc-handbook-increasing-access-to-dental-care-through-public-private-partnerships>.

Taped webinar: <http://www.slideshare.net/michiganpca/increasing-access-to-dental-care>

6-Care Management Interventions

Medicare Care Management Demonstration Programs

- Medicare Care Management Demonstration Programs were studied by the Congressional Budget Office as published in January 2012 in a manuscript: “Lessons from Medicare’s Demonstration Projects on Disease Management and Care Coordination.” Massachusetts General Hospital and its affiliated physician group participated in the *Care Management for High-Cost Beneficiaries* demonstration. This program reduced admissions by 19-24%, and stood out among the other programs.
- The program was most closely coordinated with the health delivery system, and featured extensive physician input in the program’s initial design and evolution and support from the hospital’s senior management.
- The care managers are staff members of primary care physician practices and have access to EMRs. Patients receive the vast majority of their care within the integrated delivery system and the hospital notifies care managers when their patients are hospitalized or admitted to the ER.
- Care managers interact with patients by telephone and in person during physician office visits and hospital stays, and have access to pharmacists to address potential problems with medications. Eligibility for the program is directed to patients whose Hierarchical Condition Categories (HCC) scores and past Medicare expenditures exceed specified amounts.

<http://www.hscrc.state.md.us/documents/commission-meeting/2014/07-09/post/3-Clinical-Management-Report-2014-07-03.pdf>

San Francisco Department of Public Health, Care Coordination of High Utilizers of Multiple Systems (HUMS). San Francisco, CA

- The San Francisco Health Network Transitions Division identifies high risk patients by utilizing a two dimensional approach referred to as the HUMS (High Users of Multiple Systems) methodology:
 - Dimension 1 is level of urgent/emergent service use including medical, psychiatric, substance use; and
 - Dimension 2 is care fragmentation where the individual appears in at least two of the three care areas.

This measure of systems use is used as a proxy for needing care coordination.

- Care coordination is targeted to the top 5% of individuals for the purpose of improving health outcomes and reducing overall cost.
- After implementation of the targeted care coordination program, the high risk top 1% of individuals now account for 18% of costs -- a reduction from 25%; and the high risk top 5% of individuals now comprise 46% of costs – a reduction from 55%. Cost savings are being reallocated to lower risk patients.

<http://www.centerforhealthjournalism.org/blogs/meet-san-franciscos-477-most-expensive-hums-high-utilizers-medical-services>

The Bridge Program, Rush University. Chicago, IL

- A nationally recognized, innovative Program to help elderly living in the community stay in their homes by focusing on transitions of care from hospital to home. The program uses social workers to increase the involvement of community resources in supporting the elderly.

<https://www.rush.edu/services-treatments/geriatric-services-older-adult-care/enhanced-discharge-planning-program-rush>

7- Promoting Health and Linkages with the Health Care System in Latino Communities

Building Community Support for Diabetes Care, Open Door Health Center. Homestead, FL

- Open Door Health Center is a free clinic providing care to uninsured from a diverse group of residents, predominately Latino, many of which are farm workers. Funded by the RWJ Foundation, Open Door developed a collaborative demonstration project that accomplished the following:
 - Community Health Worker Program to provide diabetes education and peer support.
 - Diabetes group visits with a strong self-management and peer support component.
 - Diabetes education sessions
 - Case management
 - Lifestyle activities -- exercise, supermarket tours, cooking classes
 - Community outreach and awareness activities

<http://diabetesnpo.im.wustl.edu/programs/DIODHC.html>

http://tde.sagepub.com/content/33/Supplement_6/166S.abstract

MHP Salud (Migrant Health Promotion)

- MHP Salud implements Community Health Worker (CHW) programs to empower underserved Latino communities and promotes the CHW model nationally as a culturally appropriate strategy to improve health.
- MHP Salud's approach to improving health is to support community members — Promotores and Promotoras — who educate and advocate for change. They serve as bridges between their communities and clinics, service providers and policymakers. They make the connections that reach people and change community health. Promotores/as provide the inspiration, direction and vision necessary to build stronger, healthier communities from within.
- MHP Salud has extensive experience offering health organizations training and technical assistance on Community Health Worker programming tailored to specific needs of the community and organizations.

<http://mhpsalud.org/>

YMCA Diabetes Prevention Program (DPP)

The YMCA's Diabetes Prevention Program has been recognized as an effective approach to Diabetes prevention in persons over 45 years of age that utilizes community-based lifestyle interventions. This program meets all CDC-recommended guidelines; the Center for Medicare and Medicaid Services recently announced that the YMCA DPP would be able to receive reimbursement under Medicare for Diabetes prevention.

<https://www.yמצapkc.org/diabetesprevention/>

<http://www.diabetes.org/newsroom/press-releases/2016/national-dpp-named-first-preventive-health-initiative-eligible-for-medicare.html>

8- Pregnancy Prevention, Prenatal Care and Pre-Term Birth

Teenage Pregnancy Prevention (TPP): Integrating Service, Programs and Strategies through Community-wide Initiatives.

This multi-center program has been instituted in Mobile AL, Hartford CT and other locations across the US. The CDC's Office of Adolescent Health has funded these programs that have targeted Latino and African-American youth aged 15-19 years through community mobilization, evidence-based strategies, increased access to reproductive health services, education and other efforts.

http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/about/Assets/community_wide_initiative_overview.pdf

Centering Pregnancy

- Centering Pregnancy is group prenatal care, bringing pregnant women due at around the same time into group visits in a comfortable setting grounded in discussion. Centering group prenatal care follows the recommended schedule of 10 prenatal visits, but each visit is 90 minutes to two hours long giving women about 10 times more time with their provider. Moms engage in their care by taking their own weight and blood pressure and recording their own health data with private time with their provider.
- Numerous published studies demonstrate that women engaged in Centering Pregnancy have healthier babies and that Centering nearly eliminates racial disparities in preterm birth at no additional cost. A nationally recognized, multi-site, randomized controlled trial (link below) with 80% African American women showed that women in group care experienced 33% risk reduction in preterm births. Women in group sessions were also less likely to have suboptimal prenatal care, had significantly better prenatal knowledge, felt more ready for labor and delivery, and had greater satisfaction with care. Breastfeeding initiation was also significantly higher in group care.

<https://www.centeringhealthcare.org/what-we-do/centering-pregnancy>

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2276878/>

9- Evidence-Based Substance Use Prevention

Preventing Substance Use Disorders in Adolescents

- Prevalence rates of tobacco, alcohol and other drug use increase rapidly from early to late adolescence, and typically peak in young adulthood. There is a growing number of evidence-based prevention programs for adolescent substance use and abuse; they are described in the manuscript “Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents” in the link below.
- It is also important to address the factors that reduce the public health impact of effective prevention programs. Most schools use non-evidence based prevention programs, family-based prevention programs often do not reach the families in greatest need, and initiating community prevention programs requires an investment of resources.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2916744/>

Preventing Deaths from Opioid Overdose: Overdose Education and Naloxone Distribution (OEND)

- An analysis of overdose education and naloxone distribution (OEND) programs in Massachusetts communities with high opioid overdose rates demonstrated a significant reduction in overdose mortality in communities implementing these programs. The study, conducted between 2006 and 2009, adjusted for potential confounders such as demographics and substance abuse treatment. T
- The rates of fatal overdose were 27% lower in communities with partial OEND implementation (1–100 trained and enrolled participants per 100,000 population) and 46% lower in communities with high levels of implementation (more than 100 trained and enrolled participants per 100,000 population). (See link below for research study.)

<https://www.drugpolicy.org/sites/default/files/AnnalsofInternalMed%20Naloxone.pdf>

<https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/16/13/08/reducing-opioid-overdose-through-education-and-naloxone-distribution>

10-Integrated Delivery

Community Care Collaborative - Integrated Delivery System (IDS)

- The Community Care Collaborative is developing an integrated healthcare delivery system for vulnerable populations in Travis County that engages patients as part of the care team, focuses on prevention and wellness, and utilizes outcome data to improve care delivery.
- The plan intends to accomplish the following
 - Centralized care coordination services: navigation, case management, utilization management, benefits screening, eligibility and enrollment

- A Health Information Technology (HIT) infrastructure that enables near-time clinical data integration, data-driven population health initiatives, and timely and efficient reporting on IDS performance
- Expanded access to specialty care services and IDS system delivery redesign
- A structure for evaluating IDS effectiveness
- A framework for moving away from a fixed-rate reimbursement system for Federally Qualified Health Centers to a value-based reimbursement methodology

<http://www.ccc-ids.org/projects/integrated-delivery-system/community-care-collaborative-draft-integrated-delivery-system-plan/>

Appendix B-5. Selected Organizational Structures for Oversight of Integrated Healthcare for Vulnerable Populations

- County-operated Medical Service Program counties have the authority to contract out for the administration of their indigent care programs; and the Medically Indigent Service program counties manage their own programs. Both programs report to County Board (California counties operating coverage programs for the uninsured.)
- County-operated Health Care Plan for low-income, uninsured residents. Funds for one-half cent sales tax is deposited into an Indigent Health Care Trust Fund used specifically to provide health care for low-income uninsured residents. Plan is governed by Board of County Commissioners, County Department of Health and Social Services administers the Plan's administration and reports to the Board. The Board establishes policy for the Plan with the advice of a community-based advisory board. (Hillsborough County, Florida)
- A limited purpose taxing district responsible for providing healthcare to indigent persons which is not part of County Government. The district is a separate political subdivision of a State, where the boundaries are not necessarily contiguous with the County. Governed by a Board of Managers. (Central Health, Texas)
- A 501(c)(3) corporation established to provide a framework for implementing the Texas 1115 Medicaid Waiver and an Integrated Delivery System for the provision of health care services to the uninsured and underinsured populations in Travis County. (CommUnity Care, Travis County, Texas)
- A County Medical Society – an existing not-for-profit organization with a larger mission -- operates a large program (Project Access) to support healthcare for vulnerable populations. Medical Society Executive Director reports to Medical Society Board which includes Project Access in their strategic planning and budgeting. (Buncombe County, North Carolina)
- A 501(c)(3) corporation serves as catalyst and facilitator, works with an independent council composed of senior leaders from participating provider organizations to operate an accountable care entity. (Medical Home Network, Chicago, IL)

Appendix B-6. Health Information Technology (HIT) Infrastructure for Care Coordination in the Safety Net

Key players in the primary care safety net – Manatee County Rural Health Services (MCR) and Manatee Memorial Hospital – have electronic access to one another’s Electronic Health Record (EHR) which is of significant benefit for patient care. The hospital also sends an automatic, electronic alert to MCR to indicate when a MCR patient has been admitted to the hospital, enabling care coordination, timely transition care and primary care follow-up. While MCR does not have an EMR interface with Blake Hospital or an electronic alert for patients that admitted to the hospital, Blake does share a daily list of MCR patients that have been admitted, discharged or transferred, again, enabling timely transition care and primary care follow-up. This a particularly beneficial use of HIT for care coordination in the safety net. Another is Direct Secure Messaging. It is likely that many safety net providers in Manatee County have the capability of exchanging information via Direct Secure Messaging; however, it is unclear if providers are utilizing this functionality that is part of federally certified EHR technology.

The County established a portal (referred to by the County as an “HIE”) to enable safety net providers to identify patients eligible for County subsidized care, and to serve as a billing system. A contract with vendor HIE Networks was signed in April 2016 for implementation. The portal will be able to scan bills 1500 and UB-04, and create a queue and dashboard report for payment of bills. While the County intends to use the portal to pull aggregated community reports on healthcare including demographics and claims data for the patients receiving services with a County subsidy, Manatee Memorial Hospital and 6 physician practices are the only providers currently using the portal.

One large primary care provider indicated that the portal does not add value and would be duplicative to existing workflows; this provider would prefer to leverage the investment in their own systems and their own workflows. This provider also indicated that for their organization the portal is cost prohibitive – their understanding of fees includes a \$2500 interface fee, \$250 per month maintenance and data storage fee, and a \$50 per physician monthly user fee. There are also costs in designing and implementing new workflows to implement the system.

Manatee County Employee Health Benefits uses a third party administrator (TPA) to collect information from providers and a data warehouse for data analytics to identify gaps in care, clinical outreach, cost comparisons, etc. Leaders in this Department indicated that the County could leverage this system to collect information for the safety net program and serve as a claims processing system for this program as well. Ultimately, the data warehouse could integrate claims and clinical data coming from safety net providers’ EHRs to produce useful information for reporting and to drive program decisions.

As the County works with stakeholders to develop specifics related to a Community-Wide Health Care Plan, data needs may change. The County may benefit from a reassessment of its data needs and determine whether these needs will be met most expeditiously by pursuing implementation of the portal. It may be that the use of providers’ existing electronic data infrastructure and existing billing systems may be more efficient and more acceptable to providers. In addition, using the County’s existing Employee Health Benefits TPA should be seriously considered for managing claims payment, as well as providing the data warehouse and analytics.

Appendix B-7. County Public, Private and Community Resources that Affect Access to Health Care for Uninsured/Underinsured Residents

Manatee County has several resources that affect access to health care for uninsured/underinsured residents.

Resources that Improve Access to Health Care

- Manatee County Rural Health Services (MCRH) is the largest federally qualified healthcare center in the Southeast, providing primary care access to residents. MCRH has 14 locations in the County providing primary care, medical sub-specialties, behavioral health and dental services.
- Non-profit organizations work to fill gaps in care for low-income, uninsured, for example: Turning Points provides free primary care and dental care, and We Care Manatee facilitates the provision of free primary and specialty care through volunteerism.
- There are three major medical hospitals in the county: Blake Medical Center, Lakewood Ranch Medical Center, and Manatee Memorial Hospital.
- Centerstone provides psychiatric, mental health and substance abuse services on an inpatient and outpatient basis. Suncoast Behavioral Health Center is a private, acute inpatient psychiatric facility for children, adolescents and adults.
- The county has twelve EMS units with an average response time of 6.05 minutes.
- There are community organizations that facilitate healthcare access and provide resources. For example, 2-1-1 is staffed 24/7 to provide resource and referral in health and human services, and hosts an electronic resource database for use by anyone with web access. Access to these services may be limited to the extent that the population is familiar with the resources.

Resources that Hinder Access to Health Care

- The capacity for primary care, medical sub-specialties, dental care and behavioral health appear to be less than adequate for low-income uninsured given wait times for appointments, and nearly complete lack of access to some services, e.g., adult dental.
- Transportation availability is critical to accessing health care services for low-income populations. While Manatee County Area Transit (MCAT) has coverage in most parts of the County, transportation is lacking in the rural areas of the County and MCAT does not operate on Sundays.
- Medicaid reimbursement in the State of Florida is quite low when compared nationally. The State of Florida chose not to expand Medicaid to additional low-income through the Affordable Care Act. In the past several years, the Medicaid program implemented Statewide Medicaid

Managed Care, which enrolls approximately 85 percent of all Medicaid beneficiaries into managed care plans for the provision of medical, behavioral health, pharmacy, and long-term services and supports.

Appendix B-8. Inventory of Manatee County-wide Financial Contributions to Care of Uninsured/Safety Net

- Manatee County budgets \$22.4 million in FY 2015-16 for county government health care programs to serve county residents under 200% FPL with no health insurance (see Attachment A).
- Approximately \$11.7 million (52%) of the health care budget is allocated to statutorily required items the county is obligated to pay per Florida Statutes. These programs consist of medical inmate costs for jails, Health Care Responsibility Act (HCRA), Medicaid County billing match, forensic medical exams for children, mental health transportation and Manatee County Health Department.
- The remaining \$10.6 million (48%) of the health care budget is not statutorily required, with the largest portion (about half the amount) paying for hospital contracts (Blake Medical Center and Manatee Memorial Hospital) and physician payments. The second largest amount is used to pay for behavioral health and substance abuse programs at Centerstone. The remainder of the funds is used for pharmacy and specialty care services at health care clinics, administration, several pilot programs and reserves.
- The majority of these non-statutorily required funds are designed to pay for health care for county residents that are below 200% of the federal poverty level and do not have any form of health insurance.
- It is anticipated that the county will fund the health care budget for FY 16-17 at approximately the same levels as the FY 15-16 budget overall.
- Beginning in FY 17-18 the county will need to address the health care budget utilizing a new approach for revenues as the fund from the sale of the hospital (Manatee Memorial) and reserves that have been utilized are depleted.

Appendix B-9. Promising Financial Strategies for Funding Expanded Care for the Uninsured in the Manatee County Context

Factors limiting funding for the low income uninsured:

- The dedicated fund that has been used to supplement the health care budget has been depleted and reserves to keep the health care budget at the current levels will also have been used by the end of the 16-17 county budget year.
- Manatee Memorial has been allocated \$8.2m in Low Income Pool (LIP) funding for the SFY 16-17 budget. This is part of the Medicaid waiver that Florida operates under currently, and this may be the last year of the funding.

Promising financial strategies:

- Manatee Memorial is scheduled to receive \$8.2m in Low Income Pool (LIP) funds from the Florida Medicaid program in fiscal year 16-17. This is a significant increase from the \$1.0m that they received in fiscal year 15-16. The Florida General Appropriations Act (GAA) **does not** include any state General Revenue to provide the state match for LIP funding. The required state Medicaid match must be provided by local governments through Intergovernmental Transfers (IGTs) which are voluntary. The GAA schedules do not show any IGTs being provided by Manatee County, but the Florida Agency for Healthcare Administration has told county staff that “If one of the anticipated IGT providers fall out (or lowers their IGT amount) we may reach out to you to keep the program fully funded”. The total state match required for the LIP payment to Manatee Memorial is \$3.4m.
- County identification of sources of new county funds, offsets from new county funds, general revenue, and unused county dollars allocated to healthcare at year’s end to dedicate for health care program for low-income uninsured, and to meet capacity expansion for critical unmet healthcare needs for this population.
- Systems should be put in place to ensure all residents to be funded by county health care funds are assessed for eligibility for any health care coverage they would qualify for -- Medicaid, CHIP, or subsidized policies under the Health Insurance Exchange.
- Both Manatee Memorial and Blake hospitals are planning to expand their medical residency programs. Any approaches to leveraging these programs to serve the low-income uninsured should be explored.
- Central Florida Behavioral Health Network (CFBHN) serves as the managing entity for state substance abuse and mental health funding available to Manatee County. The county should work closely with CFBHN to develop behavioral health priorities and secure funding for key initiatives, including supported housing. These funds would go directly to providers in Manatee County and would be used to treat and support county residents.
- The county should explore options for additional Medicaid funding for SFY 17-18 and beyond. This would require developing positions to be discussed with members of the Florida Legislature for inclusion in the state budget. Using local dollars to leverage

additional federal funds for both the hospitals and other Medicaid providers in the county should be explored.