



NORTH BROWARD HOSPITAL DISTRICT FT. LAUDERDALE, FL

August, 2004

Executive Summary:

Since 1993 the North Broward Hospital District has operated primary care clinics for patients, regardless of their ability to pay. As the need for primary health care services has continued to grow, the number of clinics has expanded to 20. The North Broward Hospital District operates 15 of these 20 community primary care clinics, which are located in easy-access areas to ensure that diverse patient populations can easily access a clinic near them. In addition to operating the clinics, in 1999 the hospital district established a disease management program.

The disease management program is available for uninsured and Medicaid patients who visit the clinics. The goal of the program is to help patients with chronic conditions learn to manage their disease, increase their health status, and decrease the number of unnecessary emergency room visits and hospital admissions. The program is specifically for patients with maternal/child health needs or for patients suffering from HIV/AIDS, asthma, diabetes, hypertension or congestive heart failure. Patients meet regularly with a nurse at their local clinic to help them recognize the signs of declining health and understand when and where to seek care appropriately to prevent greater declines in their health status. The program is funded by grants from the state, county and local businesses, and is a partnership between the hospital district, another local hospital system, and many local community organizations. A recent study showed that the county has less racial and ethnic health disparities compared to national averages. Local hospitals have also enjoyed \$980,000 in cost avoidances due to individuals proactively managing their health and utilizing the emergency room at appropriate times.

Organization Size: Four hospitals and 35 facilities including an outpatient surgical center, physician practices and 15 primary and specialty care sites.

Program/Initiative Description:

In 1993, the county subcontracted primary health care services for the area to North Broward Hospital District. The hospital district took over two of the county's three centers that were providing low cost or free health care services. However, stronger than expected need for the clinics quickly became apparent and the program began to grow rapidly. Currently, there are 20 clinics located throughout the county; North Broward Hospital District operates 15 of the primary care clinics.

Each clinic is strategically located to ensure that all individuals have easy access to the care they need. Eight of the clinics are located in or on the campus of county elementary, middle and high schools. As the program expanded from approximately 25,000 visits per year to 164,000 visits per year, the hospital district recognized the need to help patients that were using local hospital emergency rooms for primary care. As a result, the district established a disease management system to help patients remain healthier and decrease the number of preventable emergency room visits and hospital admissions.

Using grants and funding from the state, county and local businesses, the disease management program specifically targets patients suffering from HIV/AIDS, asthma, diabetes, hypertension, congestive heart failure, and maternal/child health needs. The services are provided at each of the primary care service sites; however the program is currently only available for patients who are uninsured or enrolled in Medicaid. In addition to these services, each primary care site continues to provide primary care services to all patients, regardless of ability to pay or insurance status.

The disease management services provide a variety of service for each of the targeted health areas. For example, a clinic focusing on HIV/AIDS patients provides a variety of HIV health care services as well as an outreach program that performs early intervention services to test at-risk individuals for the disease. If an individual tests positive, the clinic provides counseling and links the patient with the health care providers they will need for ongoing care.

When patients first enter the program, they meet with a variety of health care professionals, including a nurse and a dietician. Each individual's health is assessed as low-risk, medium-risk, or high-risk for decline in their health status. Nurses meet with the patients to discuss how the organization can best meet their health care needs, and connect individuals with appropriate care providers. In addition, patients regularly participate in one-on-one sessions with a nurse at their local clinic. The meetings last as long as necessary to ensure that the patients understand how to manage their health and the next steps they need to take. Depending on the severity of each patient's needs, the patient may have a one-on-one with a nurse as often as once a week or as seldom as once a quarter. In addition to one-on-one meetings, the nurses help ensure the patients receive the care they need, including scheduling appointments and calling the patients regularly to follow-up on their health status.

Each clinic works with the local hospital to provide a continuity of care for patients. As long as a patient seeks care within the district's hospital or clinic system and is uninsured or has Medicaid coverage, there is no cost for services to the patient. A patient can graduate from the program if they obtain insurance, move, or no longer need one-on-one support from the registered nurse.

Establishment of Program/Initiative: 1999

Racial or Ethnic Disparities Problem the Program/Initiative Was Designed to Address

- Need to identify and establish an intervention for the high-users of the hospital district's emergency room and prevent unnecessary hospital admissions
- Health disparities among racial and ethnic patient populations; currently 58 percent of the area's patient population is African American and 14 percent is Hispanic

Major Objectives

- Increase the health status of patients utilizing the primary care clinics by helping them to identify their declining health status and seek care as early as possible
- Decrease the number of potentially preventable emergency room visits and hospital admissions, with an emphasis on clients who regularly are admitted to the hospital or visit the emergency room inappropriately
- Provide a continuity of care for uninsured and underinsured patients, and ensure each patient feels like they have a "medical home"

Significant Results

- A recently conducted report indicated that health outcomes in the community are above national averages among racial and ethnic health minorities
- The program estimates \$580,000 in cost avoidance for the North Broward Hospital District
- Clinical indicators demonstrate that the health status of HIV/AIDS patients is improving; 61 percent of the HIV/AIDS patients in the program have the disease under control
- Admissions of diabetic patients have declined; in a twelve-month period, admissions of diabetic patients in the program declined from 148 admissions to 80 admissions
- The focus on avoiding inpatient admissions has resulted in an increase in emergency room visits for some patients, but most of these visits did not result in an admission. This indicates that patients are learning to recognize a decrease in their health status earlier and access the care they need before their health declines further

External Partners in the Program/Initiative

- County Health Department
- State of Florida
- American Lung Association
- Broward Regional Health Council
- Pfizer
- South Broward Hospital District, another local health system
- Local school districts

- Many other community organizations

Limitations or Problems Encountered: Patients can be difficult to contact because their phone numbers and addresses do not remain constant; many of the patients' lives are not stable and they are dealing with many issues other serious issues at the same time. Therefore, staying in touch with the program is not always their top priority.

Estimated Cost of the Program, To Date:

- Grant funds have fully funded the program thus far
- Funding required depends on the number and severity of cases and the disease prevalence rate, but the total cost for salary, benefits, and other expenses is approximately \$120,000 per case manager; each case manager covers between 200-500 individuals annually

Advice to Other Organizations That May Want to Start a Similar Program

- Systems that have both inpatient and outpatient settings should work closely together and maintain the same goals to provide continuity of care for the patients
- It is important to involve the program's nurses with the physicians on the frontline
- Face-to-face contact with patients is critical; it can be difficult to reach patients via phone or mail due to uncertainty in the patients' lives

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