ITEM #63(2)

ADDITIONAL MATERIAL

REGULAR MEETING

APRIL 16, 2024

SUBMITTED AT THE REQUEST OF

COUNTY ADMINISTRATION

HMA

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Proposed Broward County Healthcare Plan

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INTRODUCTION

On March 21, 2024, the Broward County Commission directed the County Administrator to develop an initial county healthcare plan that the voters could approve through a popular referendum on the November ballot. On behalf of the Broward County Administrator, the South Florida Community Care Network, LLC, d/b/a SydCura contracted with Health Management Associates (HMA), Inc., a national healthcare consulting firm, to develop the proposed plan. Memorial Healthcare System (MHS) and Broward Health (the Districts) provided information in the preparation of this report to better understand existing services offerings, as both Districts have existing expansive programs designed to provide comprehensive indigent healthcare to the residents of Broward County.

This plan has been developed by HMA in consultation with SydCura and County personnel, including County Administration and the County Attorney's Office (the County Attorney's Office addressed only the applicable statutory standards and, more generally, legal issues). It is contemplated that the plan as adopted and implemented by Broward County would continue to be refined based on further research, stakeholder engagement, community physician input, ongoing needs assessment, and additional gap analyses. The plan set forth herein is based in large part upon information provided by SydCura and the Districts. Finally, this plan is based upon Section 212.055(4), Florida Statutes, but does not attempt to address any other state and federal requirements (e.g., mandatory benefits, financial reserves, etc.) as outside the scope of this engagement. This plan primarily focuses on the primary and preventive services and incorporates by reference the additional detail regarding the separately-developed third-party plan that details the proposed innovative, cost-effective programs (Exhibit A).

OVERVIEW

This proposed Broward County Health Care Plan will seek to identify and fill potential gaps in the safety net for Broward's most vulnerable population. The North and South Hospital Districts each already administer indigent healthcare programs that inform this plan. In addition, Broward County offers a pilot program (Broward County Heart Project) for funding Coronary CT Angiography (CCTA) and calcium screenings for insured residents that serves as one of the core elements to this plan.

CURRENT PUBLIC HEALTHCARE PROGRAMS

Current Memorial Healthcare System Programs

MHS' indigent healthcare program is a good example of the structure and services offered under both programs. Since the early 1990s, MHS has been operating the primary care services for the indigent and medically poor in South Broward. The original clinic located on Pembroke Road was previously operated and fully financed by Broward County. Broward County entered into an agreement with MHS transferring operational responsibility to MHS. MHS, over the years has built out a substantial array of primary care access points across South Broward, including 25 providers located at 10 fixed sites, as well as two mobile healthcare units that provide both pediatric and adult services. The current contract compensates MHS $4,987,957 per year and includes several HEDIS quality and service level metric goals. Today, MHS's primary care clinics serve more than 37,600 residents of South Broward providing them comprehensive primary care services within the construct of a Level 3 National Committee on Quality Assurance (NCQA) Primary Care Medical Home (PCMH) model, which is the most advanced type of PCMH. The primary care services are fully complimented with access to a comprehensive network of medical and surgical specialists, hospital services and other ambulatory services within MHS. The excess cost of providing healthcare services to the indigent and medically poor over the compensation received from Broward County is approximately $7,200,000 on an annual basis.

MHS offers all residents of South Broward access to care, regardless of their ability to pay under various financial assistance programs more fully described below:

1. Charity Care Program: All people with family income levels are at or below 200% of the Federal Poverty Line (FPL) are provided free care.
2. Sliding Scale Discount Program: All persons with family income levels between 201% to 400% FPL are eligible for substantial discounts for health care services ranging from 90% to approximately to 60% with the resulting amount limited to no more than 10% of their annual family income, and further limited to regulatory maximums, set annually, pursuant to rules under IRS 501(r) guidelines.
3. Other Financial Assistance: For indigent and medically poor persons covered by health plans with high deductible, co-insurance and medication copays MHS offers assistance to address barriers through a drug discount program.

Current Broward Health Programs

The North District also has a comprehensive uninsured program with similar eligibility criteria and structure outlined above, with financial assistance available to those with family income levels below 300% of the FPL. In addition to their ongoing commitment to reducing the financial burden on the taxpayers, they converted their network of primary care to Federally Qualified Health Centers, providing additional federal funding and a high level of quality and compliance standards. Broward Health operates 11 Clinics strategically located throughout the northern district of Broward County providing primary care, prenatal care, pediatrics, mental health, dental services and specific programs for the homeless community. Broward Health also brings healthcare to the patient by operating two Mobile Health Units that deliver primary and preventative care.

Both districts collaborate on the development of their eligibility criteria and work through SydCura to administer comprehensive benefits to the uninsured residents of Broward County and streamline operations. As the North District is responsible for approximately 2/3 of the Broward residents, the County funding is approximately $8.4 million. The excess cost of providing healthcare services to the indigent and medically poor over the compensation received from Broward County is approximately $8,200,000 on an annual basis.

PROPOSED BROWARD COUNTY HEALTHCARE PROGRAM

Eligibility

To qualify for the proposed healthcare plan, individuals must be “qualified residents,” as defined by Section 212.055(4)a.4., Florida Statutes, which includes (a) persons certified by Broward County as indigent persons, (b) persons certified by Broward County as medically poor, and (c) persons participating in innovative, cost-effective programs approved by Broward County. This plan is based upon the following definitions and guidance:

“Indigent” means persons who are certified by Broward County as meeting all of the following criteria: (i) gross family unit income is below the poverty level for a household of that size; (ii) not eligible to participate in any other state or federal program which provides hospital care (i.e., Medicaid or Medicare); (iii) family unit's assets do not exceed the established limits; (iv) has either no or inadequate private insurance; and (v) does not reside in a public institution as defined under the medical assistance program under Title XIX of the Social Security Act. To the extent a different definition of “indigent” is legally required, the legally required definition shall instead be applicable.

“Medically poor” means persons who are certified by Broward County as having insufficient income, resources, and assets to provide the needed medical care without using resources required to meet basic needs for shelter, food, clothing, and personal expenses; or not being eligible for any other state or federal program, or having medical needs that are not covered by any such program; or having insufficient third-party insurance coverage.

“Persons participating in innovative, cost-effective programs” means persons who are participating in the preventive cardiac and cancer screenings outlined in this plan, independent of whether the person also qualifies as indigent or medically poor. Note that in many, if not most, instances, persons under this category will also be a “qualified resident” on the basis of qualifying as “medically poor” in light of the likely insufficiency of third-party insurance coverage for the innovative preventive screenings at issue.

In all instances, the person must be a Broward County resident, which is defined as persons who have established, and currently maintain, Broward County as their domicile (i.e., primary residence) as demonstrated by homestead status, election registration, or other documentation as determined appropriate by the Plan administrators. An applicant that demonstrates uninterrupted residency in Broward County for the twelve (12) months immediately preceding the date of the application for qualification shall be presumed to be a Broward County resident, absent clear evidence to the contrary. To the extent a different definition of "qualified resident" is legally required, the legally required definition shall instead be applicable.

Cost-Sharing

An important issue is to ensure that the programs funded by this plan remain financially sustainable. Therefore, certain limitations and cost-sharing provisions could apply. Enrollees with incomes between 200-400% of the federal poverty level could receive prorated financial assistance. Patient responsibility could be capped at 10% of annual income for all members under 400% FPL to guard against medical debt. Modest copayments may be instituted for certain specified services to encourage appropriate utilization.

Enrollment

Interested individuals may apply for either program online through a user-friendly web portal or in-person at conveniently located enrollment sites throughout the county. The streamlined application could collect the necessary residency, income, and asset information to determine eligibility. Participants may be required to re-establish their enrollment annually by providing updated personal and financial documentation.

Public Financing

Both hospital districts receive direct payments from Broward County to subsidize the provision of healthcare services to indigent residents. These payments are separate from the ad valorem tax revenue generated by each district and separate from the funding provided by Broward County for the existing CCTA screening pilot and other County programs. The Districts each carry hundreds of millions of dollars in foregone costs as a benefit to the communities of Broward County. The Districts operate with existing funding outside the scope of this healthcare plan according to their chartered obligations to care for the most vulnerable and needy residents of the County regardless of their ability to pay, including caring for individuals with chronic healthcare needs and orphan diseases who may not be able to receive treatment from a private facility because the treatment for their conditions may not be considered profitable. All potential funding sources for an expanded program would need to be carefully considered to ensure no interference with existing operations of the districts per their chartered obligations as local healthcare special taxing districts. This plan would provide funding toward some of these services, if eligible under the applicable statute.

Providers

Upon acceptance into one of the programs, members would select a primary care clinic and physician who would serve as their medical home, similar to the process in place today for the District programs. This provider would coordinate all aspects of the member's care, including referrals to specialists when needed. To promote continuity and cost-effectiveness, enrolled individuals can obtain all covered non-emergency services through a curated network of high-quality but affordable hospital and outpatient providers.

Covered Services

The proposed broad range of health care services covered by this plan include the following, which may mirror and supplement the primary and preventive care services currently being provided by the Districts under the current funding provided by the County. This overlap provides opportunities for increased funding, greater efficiencies, and utilization of innovative, cost-effective programs. Based upon feedback and results throughout the implementation of the plan, as well as community feedback and ongoing needs analysis, these covered services may be modified and expanded to include additional types of services (e.g., vision, dental, etc.):

- *Primary care clinic visits:* Routine check-ups, preventive services, and management of common health conditions provided by a primary care physician or clinic that serves as the patient's first point of contact and coordinates their overall care. One of the primary focuses of this plan is on cardiac health and cancer prevention, including treatment where appropriate. Primary care clinic visits can be a first point of contract to facilitate these preventive cardiac and cancer screening services to facilitate early detection and treatment.
- *Inpatient hospital care:* Treatment provided to patients who are admitted to a hospital and stay overnight or for an extended period, typically for serious illnesses, injuries or surgeries that require close monitoring. This would include provision of services by a Level I trauma center.
- *Specialty physician care with PCP referral:* Expert treatment for specific health problems or body systems (e.g. heart, skin, digestive) that require more specialized knowledge and skills than primary care, accessed through a referral from the patient's main doctor to ensure coordinated care. Note: MHS program patients have access to specialty and outpatient services at MHS.
- *Laboratory and x-ray services:* Diagnostic tests using blood, urine or other samples (lab work) or imaging scans (x-rays, MRIs, CT scans, U/S, PET Scans) to detect, diagnose and monitor disease or check bodily functioning and internal structures. This plan includes special emphasis on cardiac imaging services utilizing the coronary CT angiography (CCTA) test (or, where appropriate, the calcium scoring (CAC)).
- Prescription medications*:* Drugs prescribed by a licensed provider to treat or manage various health conditions, covered in part or in full by the program based on a tiered copayment structure that incentivizes generic over brand-name when appropriate.
- *Durable medical equipment and supplies:* Reusable medical items such as wheelchairs, walkers, oxygen tanks, blood sugar monitors, and wound care supplies that are prescribed by a doctor for home use to aid in mobility, functioning or the treatment of a health condition.
- *Emergency care:* Immediate medical services needed to diagnose, treat and stabilize patients with sudden, life-threatening symptoms or conditions such as heart attack, stroke, severe accidents or acute illness, covered at any hospital ED regardless of network status.
- *Access to healthy living/wellness programs:* Optional group or self-directed education, coaching and activities aimed at promoting healthy behaviors, managing chronic conditions and preventing disease, such as nutrition classes, fitness challenges, disease management and smoking cessation.

Preventive Services

In the United States, chronic illnesses cause considerable health and economic burdens. Heart disease and stroke are the leading causes of death in the United States, claiming over 877,500 lives annually, which accounts for one-third of all fatalities. The financial impact of these diseases is substantial, with an estimated

$216 billion in healthcare expenses and an additional $147 billion in productivity losses at work each year. Annually, over 1.7 million Americans receive a cancer diagnosis, with nearly 600,000 succumbing to the disease, positioning it as the nation's second most common cause of death. The financial burden of cancer treatment is escalating, projected to surpass $240 billion by the year 2030.

Implementing measures to prevent and control these diseases can yield substantial health improvements and financial savings.

The proposed plan would offer a wide range of preventive services like screening and counseling. Preventive services can also be prescribed by a doctor outside of standard parameters based on their medical judgment, such as innovative programs including cardiac screenings using coronary CT angiography (CCTA) tests and cancer screenings.

Clinical Guidelines for Preventive Services

Note that many preventive services are only recommended for certain patients based on age, gender, personal medical history, family medical history, and/or symptoms and that the existing indigent healthcare programs offered by the North and South Broward Hospital Districts follow the guidelines issued by the National Preventive Services Task Force, national medical societies, or other authoritative sources. As an example of clinical guidelines for determining eligibility for a particular preventive service, following are the clinical guidelines for determining if it is recommended for a particular patient to receive a CCTA. CCTAs are a form of medical imaging that can be used to diagnose coronary artery disease. These tests are not universally recommended for all populations due to their specific indications, potential risks, and the necessity for appropriate patient selection. Generally, CCTAs are recommended for:

1. *Symptomatic patients with intermediate risk of coronary artery disease (CAD):* Patients who have chest pain or other symptoms suggestive of CAD but whose risk is not clearly defined by their clinical presentation and initial testing may benefit from a CCTA. This test can help clarify the diagnosis and guide treatment decisions.
2. *Patients with unclear or inconclusive stress test results:* If a patient has undergone stress testing to assess for CAD and the results are unclear or inconclusive, a CCTA may provide additional information to help in making a definitive diagnosis.
3. *Pre-operative assessment for non-coronary cardiac surgery:* In some cases, CCTA is used to evaluate the coronary arteries before surgeries that are not directly related to coronary artery disease, such as valve surgery, to ensure there isn't significant undiagnosed CAD that could complicate the procedure.
4. *Evaluation of coronary artery anomalies:* CCTA is an effective tool for visualizing the coronary anatomy and can be used to diagnose congenital anomalies of the coronary arteries.

5. *Assessment of coronary artery bypass grafts and stents:* For patients who have previously undergone coronary artery bypass graft surgery or who have stents, CCTA can be used to assess the patency and condition of these interventions.
6. *High-risk individuals with atypical symptoms:* In certain high-risk patients, such as those with a strong family history of CAD, diabetes, or other significant risk factors, CCTA might be considered if symptoms are not typical but suspicion for CAD remains high.

Coronary CT angiographies should be utilized with a careful balancing of the specific nature of the test, its indications, potential risks, and cost-effectiveness. These risks and benefits are contemplated in the current pilot project. The decision to use CCTA is made on a case-by-case basis, considering the individual's risk factors and the potential benefits and risks of the procedure. The goal is to find the right balance between obtaining useful diagnostic information and avoiding unnecessary risks.

The Broward Heart Project

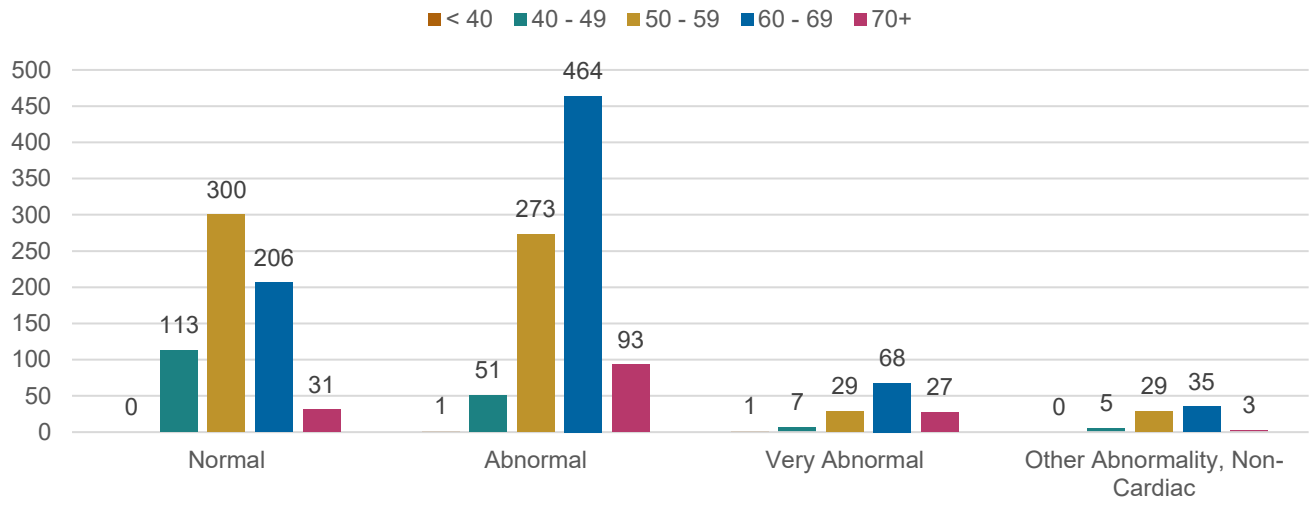
The Broward Heart Project is a pilot program initiated by Commissioner Mark Bogen to provide funding for free CCTAs to Broward County residents aged 45-70. $10m was allocated by the Broward County Board of County Commissioners for the entire project. Calcium Screenings are also provided under the program where there is a clinical indication (e.g. a dye allergy) a CCTA may not be appropriate based on the prescribing and participating physician's recommendations. The goal is to identify individuals with blockages in their coronary arteries who may be unaware of their condition, allowing them to seek appropriate medical treatment and reduce their risk of heart attack. Participants must meet certain eligibility criteria, including having active health insurance and at least one risk factor such as diabetes, hypertension, high cholesterol, smoking, or family history of coronary disease.

The program involves a partnership with several healthcare providers in the area, and participants can schedule appointments online after completing a screening questionnaire and consent forms. Results are categorized as normal, abnormal, very abnormal, or other abnormality, with recommendations provided for follow-up with a medical practitioner as needed. Criteria for eligibility for the program were established by local physicians with expertise in the provision of these or similar screenings.

The impact of the Broward Heart Project has not been the subject of a peer-reviewed study, nor could it be in its current form since the necessary protocols were not conducted at the outset. Entities involved in human subjects research should have policies in place to protect study participants. This often involves oversight by an Institutional Review Board (IRB) or similar ethics committee that reviews research proposals to ensure the protection of participants' rights and welfare, the necessity of informed consent, and the minimization of risks to participants.

SydCura has facilitated the scheduling of approximately 3,200 individuals to date and reported results from approximately 1,700 screenings to date with scheduling ongoing. Results thus far indicate that approximately 59% of the participants have abnormal (moderately or severely) results that merit follow-up with their personal physicians. Results from the program to date are shown in the figure below. SydCura has established an infrastructure for the project including a participant-facing website with scheduling capabilities at contracted facilities to ensure remaining funding can be devoted to ongoing screening throughout the lifetime of the project.

Figure 1. Results by Age Group



Additional Services

Beyond the core medical benefits, the existing indigent healthcare programs offered by the North and South Hospital Districts in Broward County could connect members to resources that address the social determinants of health and encourage wellness. Participants can take advantage of innovative healthy living programs, including fitness classes, nutritional counseling, smoking cessation support and disease-specific education. These value-added services could be delivered both in-person at community health locations and virtually to maximize access and engagement.

Other Requirements

Section 212.055(4), Florida Statutes, provides some general categories that this plan must address:

1. *The Plan must "fund a broad range of health care services for both indigent persons and the medically poor, including, but not limited to, primary care and preventive care as well as hospital care."*

   The proposed programs offer a broad range of health care services for qualifying indigent persons and the medically poor, as outlined above, and include coverage components typically identified as primary, preventive, and hospital base care.

2. *The Plan must "address the services to be provided by [a] Level I trauma center."*

   The proposed program would fund $6.5 million annually for a Level I trauma center. The Districts manage facilities designated as Level I and II Trauma Centers, including two of only seven Level I trauma centers in Florida.

3. *The Plan "shall include, without limitation, services rendered by physicians, clinics, community hospitals, mental health centers, and alternative delivery sites, as well as at least one regional referral hospital where appropriate."*

   The proposed programs include services rendered by both Districts and each of these referenced provider types.

4. *The Plan must serve "qualified residents" which include indigent persons as certified by the authorizing county," or "meeting the definition of the medically poor," or "participating in innovative, cost-effective programs[.]"*

As noted above, the qualified residents include indigent persons and the medically poor and those participating in innovative, cost-effective programs such as the Pilot project. The Pilot currently targets only an insured population in order to ensure health insurance for any needed follow-up for participants; in light of the additional primary and preventive and hospital care services included in the proposed plan, the implementation of this plan would expand the Pilot project to also include uninsured or underinsured populations. This plan contemplates that the County utilizing surtax proceeds would be the payor of last resort, after all other applicable funding sources (e.g., public or private insurance, etc.) have been utilized.

OPPORTUNITIES FOR FUTURE GROWTH

As the Plan is implemented, it should be reviewed at least annually including gathering community and stakeholder input as the Plan progresses to adjust, if and to the extent appropriate, new or additional services that should be provided and other adjustments based on a community health needs assessments. For reference, the most recent community health needs assessments performed by the Districts are attached (Exhibits B and C).

SUMMARY

By furnishing a broad spectrum of services through designated provider networks and incorporating proven cost-control strategies, the proposed plan will build on the successful existing Pilot program while expanding to provide a broad range of primary and preventive care to local residents. Cooperation with existing programs offered by the Districts will ensure the efficient utilization of resources.

In preparation of this report, the Districts have reiterated their commitment to provide high quality and effective healthcare access to the residents of Broward County regardless of an individual's ability to pay, and are prepared to collaborate with the County in order to ensure existing programs and any additional funding are administered efficiently and take into account the County's most vulnerable and underserved populations.

ABOUT HEALTH MANAGEMENT ASSOCIATES

Health Management Associates (HMA) is a leading independent national research and consulting firm in the healthcare industry. Founded in 1985, today we are more than 700 consultants strong and still growing. We have more than 30 locations across the country, with local expertise and intel in all 50 states plus the District of Columbia and Puerto Rico through HMA State Connect. We help clients stay ahead of the curve in publicly funded healthcare by providing technical assistance, resources, decision support and expertise.

Our team comes from all sides of the publicly funded healthcare arena. Formerly, they excelled as:

- State Medicaid directors, mental health commissioners and budget officers
- CEO, COO, CFO and other hospital, health system and state-based health insurance marketplace leaders
- Managed care executives
- Physicians and other clinicians who have run health centers and integrated systems of care–many still practice medicine
- Policy advisors to governors and other elected officials
- Senior officials from the Centers for Medicare & Medicaid Services (CMS) and the Office of Management & Budget (OMB)
- Executives of community-based organizations, foundation program directors and civic leaders, university professors, researchers and statisticians, and LGBTQ and HIV community leaders

Our team has an intimate understanding of the challenges and constraints our clients face, and we work across disciplines and geographical areas to put that knowledge to work for every client. Simply put, no one knows publicly funded healthcare like we do.

ABOUT THE AUTHOR

Stephen Palmer's career has been focused on Medicaid, healthcare information technology, telehealth, and health professions regulation. He spent more than a decade serving the State of Texas and understands state health policy and programs. He is a skilled researcher, writer, and analyst with expertise in statistical methods and data modeling.

Before joining HMA, he worked as a principal in the Intelligence Practice Area of Leavitt Partners Solutions, focusing on research and state health policy. Dr. Palmer also ran his own consulting firm for more than five years, helping organizations navigate the intersections of healthcare, government, and technology.

Dr. Palmer served as director of the Office of e-Health Coordination for the Texas Health and Human Services Commission and as the Texas State Health IT Coordinator from 2010 to 2013. As the state health IT coordinator, he managed the Texas state health information exchange program and coordinated the other federally funded healthcare information technology initiatives throughout the state.

During his tenure with the State of Texas, he served as a healthcare policy advisor to Governor Rick Perry, providing guidance on a wide range of issues. He worked as a policy advisor on Medicaid and the Children's Health Insurance Program for the Deputy Executive Commission for Health Services at the state Health and Human Services Commission and as a policy staff member in the Texas Senate.

Prior to his public policy career, Dr. Palmer was an information technology consultant focusing on interface programming and database administration.

Dr. Palmer earned his doctorate in public policy and his master's degree in public affairs at the University of Texas. He earned and his bachelor's degree in physics and philosophy from Rice University. His doctoral research focused on health information technology policy.

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EXHIBIT 1

Broward County Preventive Health Care Program Plan

Cardiovascular disease is the leading cause of death globally and in Broward County. Approximately 1 in every 2 people in the United States suffers from some type of cardiovascular disease. As a state, Florida has the 7th highest incidence of heart attacks in the country. About 655,000 Americans die from heart disease each year, which is equivalent to 1 in every 4 deaths. Coronary artery disease (CAD) is the most common cause of premature and avoidable death in the United States. Sudden cardiac death is the first sign of heart disease in more than half of patients with CAD.

This Plan provides innovative, cost-effective methods of screening to detect CAD and to help combat the number one cause of death in Broward County. Current standards of care for detecting heart disease are insufficient, resulting in ineffective screening strategies in asymptomatic individuals and overutilization of invasive cardiac testing in symptomatic individuals. Too often individuals presenting to emergency departments with chest pain are sent home despite undetected imminent cardiac risk. Coronary computed tomography (CT) is a noninvasive, cost-effective method of detecting coronary artery disease.

In addition to providing innovative cardiac screening services to all Broward County residents, this Plan provides (i) a broad range of primary and preventive care services for indigent and medically poor populations of Broward County residents; and (ii) a second phase that will expand preventive and diagnostic screening services to include the most prevalent types of cancer.

1. Specific Recommended Services to be provided:

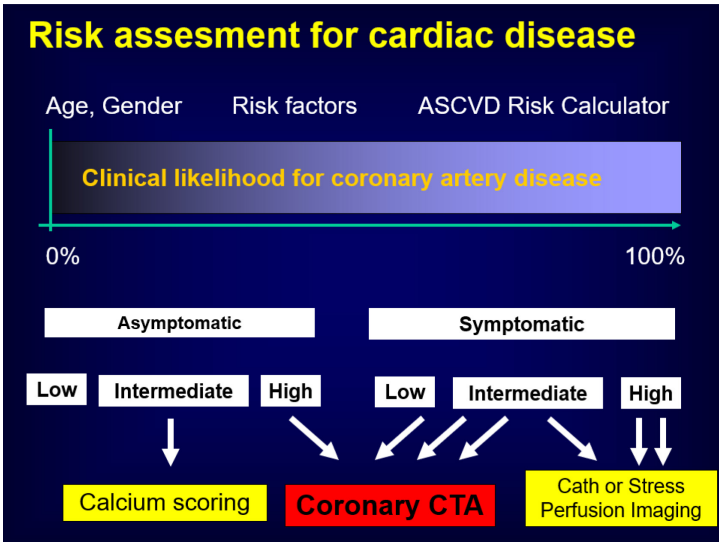
a. Primary Care and Preventive Care

The primary care and preventive care services under this part of the Plan will be available to Broward County residents who are indigent or medically poor.

This part of the Plan provides for a broad range of primary and preventive care for persons who are indigent or medically poor. The primary and preventive services provided under this part of the Plan will include the primary care services currently funded by the County, and will expand the primary and preventive services funded for indigent and medically poor persons, including to provide Cardiovascular Disease Prevention Clinics for clinical assessment of cardiac health and risk stratification.

These Cardiovascular Disease Prevention Clinics would increase access to primary care and preventive care aimed at cardiovascular health, particularly to those with greater social stress. Cardiovascular risk evaluation and treatment will be protocol driven and thus improve quality and consistency of care. All eligible adults (indigent or medically poor) between the ages of 18 – 75 years old without established cardiovascular disease should undergo cardiovascular risk assessment at a Cardiovascular Disease Prevention Clinic. Appropriate individuals will be referred for subclinical atherosclerosis imaging – either calcium scoring (CAC) or a coronary CT

angiography (CCTA) – at an Imaging Facility (detailed below) based upon relevant factors such as age, gender, risk factors, and symptoms, as shown in the diagram below.



The Cardiovascular Disease Prevention Clinics will provide follow-up care and treatment for the prevention of CAD consonant with national guidelines, including advising on diet, physical activity, and tobacco use.

The clinics and the imaging facilities (detailed in the following section) must be sited in a manner to ensure accessibility for the persons utilizing the services, with special emphasis on accessibility for persons who are indigent or medically poor. The locations of the clinics and the imaging facilities must be based on consideration of at least the following factors: accessibility for users (including consideration of issues such as public transportation, childcare, and hours of operation); current location of primary care clinics (included publicly-funded primary care provided by local hospitals and federally qualified health centers); location of and proximity to high-risk populations; current utilization rates of existing clinics; current screen capabilities of existing clinics; ability to expand current clinics to include screening technologies (including physical footprint, financial abilities, current patient utilization numbers, etc.). Locations to be utilized may include existing primary care clinics, federally qualified health centers, cardiology offices, newly established prevention clinics, or other locations identified by the Plan administrators. A significant emphasis should be placed on healthcare literacy and facilitating community understanding and appreciation for the value of prevention care at these clinics.

b. Imaging Facilities:

The imaging facilities and imaging services under this part of the Plan will be available to all Broward County residents (not merely residents who are indigent or medically poor) for preventive care but only to the extent such facilities and services are not covered under existing private or public medical care or coverage.

Imaging services with Calcium Score testing (CAC) and Coronary CT Angiography (CCTA) will be provided that meet or exceed the following criteria:

- For CAC testing, multi-detector CT scanners (MDCT) that are at least 16-slice; preferably a 64-slice CT scanner or above is preferred in order to improve image quality and minimize radiation dose.
- For Coronary CT Angiography (CCTA) testing, multi-detector CT scanner that are at least 64-slice; preferably 256-slice is recommended to achieve superior image quality, better diagnostic accuracy, and to minimize exposure to radiation dose.

These technologies can be sited at clinics or at standalone facilities, or implemented as mobile units, or a combination of the foregoing, depending on a number of factors, including existing clinic capabilities, expansion opportunities, target locations and populations, and how the program is administered. A detailed review should be undertaken of the current location, capabilities, and utilization of existing scanning equipment at availability facilities. Special care should be taken to tailor the quantity and capabilities of the scanning equipment to the expected needs of and projected utilization by the local community, so as to avoid financial exposure in the acquisition of underutilized equipment (e.g., overburdening health care facilities with additional costs not offset by appropriate utilization) and appropriate allocation of technology and funding to permit the intended medical benefits to reach all areas of the population, with special emphasis on the indigent and medically poor communities.

Financial considerations include whether to utilize existing imaging equipment (depending upon availability and capability at existing locations), provide new imaging equipment, or provide funding toward to acquisition of new imaging equipment. A market and economic analysis should be done to determine the appropriate method of ensuring the necessary imaging equipment is available and appropriately utilized. One method would be to allow market forces to provide for the acquisition of the necessary equipment based upon public funding of the services to be provided utilizing that equipment (e.g., reimbursement for services based upon a percentage of the Medicare fee schedule); under this approach, the medical market would adjust to the implementation of this Plan and the associated funding for primary and preventive cardiac health services, and the medical community would provide the equipment and services, assume the associated capital obligation, and reap the associated tax benefits. Another method would be for the County to fund the needed technology, whether through direct acquisition and distribution or through the provision of funding to the medical facilities to acquire the equipment. Under this method, the County could incentivize the placement of the imaging equipment in appropriate locations by enhanced funding to medical facilities in the desired locations.

c. Hospital Care

The hospital care services under this part of the Plan will be available to Broward County residents who are indigent or medically poor.

One of the goals of this Plan is to ensure that local hospitals treating patients presenting with acute chest pain have adequate imaging technologies, including a cardiac capable MDCT scanner (minimum of 64-slice MDCT scanner and preferable a 256-slice MDCT scanner), as well as adequate and trained staff for CCTA interpretation as delineated above for proper triage and a cardiac catheterization lab in case the need of percutaneous coronary intervention is required. The local assessment of the location of existing imaging equipment should include confirmation that the local hospitals have a sufficient number and sophistication of cardiac capable MDCT scanners.

Chest pain and other symptoms suggestive of obstructive CAD (e.g., shortness of breath) are among most common presentations in both hospital setting/emergency department and outpatient clinics (internal medicine, primary care, family medicine and cardiology). For patients

presenting with chest pain or angina to the Emergency Department or to the hospital setting, CCTA will be the first line strategy prioritized for low to intermediate risk patients.

The Plan includes the statutorily-required funding requirement of $6.5 million annually to a Level I Trauma Center in Broward County. There are two Level I Trauma Centers in Broward County: Broward Health Medical Center (affiliated with North Broward Hospital District), and Memorial Regional (affiliated with South Broward Hospital District).

2. Funding Methodologies Reimbursement Agreements

The funding methodologies and reimbursement strategies contemplated would utilize existing healthcare plans and programs, both private and public, and existing primary care public funding. For the services covered under Section 1(a) and 1(c) above (primary and preventive care; hospital services), the funding methodologies would include and expand upon current funding arrangements with local hospitals and services providers.

For the services covered under Section 1(b) above (imaging facilities and imaging services), the funding methodology will be to provide funding for preventive screenings solely to the extent such services are not covered by existing private or public health care or insurance. Typically, public and private health insurance does not cover the preventive CAC and CCTA screening called for in this Plan; therefore, the implementation of this Plan would expand reimbursement for these preventive services for persons who are indigent or medically poor to include the recommended cardiac primary and prevention services and screening detailed herein, but only to the extent such services are not covered by existing public or private insurance or other funding. The patient's existing coverage (if any), whether public or private, would be the initial payor, to the extent such services are covered; the Plan funding would be utilized only if the patient's existing coverage is insufficient and/or there is no coverage for the preventive services. Special attention should be directed during Plan implementation to ensure healthcare plans are not negatively incentivized to exclude coverage from private healthcare plans.

In addition, for all Broward residents, this Plan would provide for the availability of screening equipment at convenient locations throughout the County and qualified professionals to assess the scores and risk profiles of the target population. To provide for the availability of the screening equipment, possible options include incentivizing procurement of the equipment by locations (e.g., through reimbursement for screening services), funding some or all of the cost of the acquisition by the locations, or County procurement of the necessary equipment; the administrators of the Plan would determine the appropriate method for ensuring the availability of the equipment, which may vary based upon the location at issue.

Applicable agreements will include reimbursement methodologies that take into account the cost of services rendered to eligible patients and are structured to allocate higher reimbursement rates to facilities that will provide a higher proportion of care to indigent or medically poor patients, facilities that invest in the technology needed to achieve better imaging services, and facilities that will provide superior services with better quality care and superior outcomes,

including through promoting care coordination and appropriate case management. These agreements should also promote the use of these advancement technologies for cardiac health care in medical services and include appropriate mechanisms for cost containment. To effectuate the foregoing, the County could negotiate an agreement with a single healthcare plan administrator or negotiate agreements with the applicable healthcare plans. Any hospitals owned and operated by government entities must, as a condition of receiving funds under this Plan, afford public access equal to that required of public meetings under Section 286.011, Florida Statutes.

3. Preventive and Early Diagnosis of Cancer

Cancer is the second leading cause of death, after heart disease, in the United States in 2019. Lung cancer was the leading cause of cancer death, followed by cancers of the colon and rectum, pancreas, female breast, prostate, and liver and intrahepatic bile duct. One of the most effective ways to reduce cancer morbidity and mortality is through early detection and treatment. Increasing awareness and use of the available screening technologies for breast, cervical, colorectal, and lung cancer can contribute to increased survival and fewer deaths. Therefore, the second phase of the Plan will focus on the preventive and diagnostic cancer screening to address the number two leading cause of death for Broward County residents, with particular emphases on implementing innovative programs to facilitate outreach, such as mobile screenings as a cost-effective alternative to traditional methods of service delivery, and on improving the efficacy of screenings, such as through a preventive care program utilizing advanced technology.

4. Eligible Populations and Recommended Funding Allocations

All utilization of the surtax-generated funding must be consistent with the requirements of Section 212.055(4), Florida Statutes, and all other applicable law. The funding allocations set forth herein are the initial allocations of the funds; allocations and uses will vary as this Plan is amended from time to time. Designated staff and medical personnel will periodically evaluate the Plan and the allocation of funds and recommend appropriate amendments and adjustments for consideration by the Board of County Commissioners. The version of the Plan most recently approved by the Board will be the operative Plan at any given moment.

a. Eligible Populations

“Indigent” means persons who are qualified by Broward County as meeting all of the following criteria: (i) gross family unit income is below the poverty level for a household of that size; (ii) not eligible to participate in any other state or federal program which provides hospital care (i.e., Medicaid or Medicare); (iii) family unit's assets do not exceed the established limits; (iv) has either no or inadequate private insurance; and (v) does not reside in a public institution as defined under the medical assistance program under Title XIX of the Social Security Act.

“Medically poor” means persons who are qualified by Broward County as having insufficient income, resources, and assets to provide the needed medical care without using resources

required to meet basic needs for shelter, food, clothing, and personal expenses; or not being eligible for any other state or federal program, or having medical needs that are not covered by any such program; or having insufficient third-party insurance coverage.

"Broward County resident" means persons who are indigent, medically poor, or to the extent otherwise approved by Broward County for participation in the innovative health care programs set forth herein, provided such persons have established, and currently maintain, Broward County as their domicile (i.e., primary residence) as demonstrated by homestead status, election registration, or other documentation as determined appropriate by the Plan administrators. An applicant that demonstrates uninterrupted residency in Broward County for the twelve (12) months immediately preceding the date of the application for qualification shall be presumed to be a Broward County resident, absent clear evidence to the contrary.

For any person eligible for services under this Plan who is indigent, medically poor, or a Broward County resident, this Plan and Broward County shall serve as the payor of last resort; funding will be provided under this Plan only to the extent the applicable services are not covered by existing private or public medical care or insurance.

b. Funding Allocations

Based upon the health care needs of Broward County, with special emphasis on the needs of the indigent and medically poor, the recommended allocation of surtax funding to the above-referenced services and program is as set forth below. In accordance with state law, the total funds (100%) allocated under this proposal shall be equal to 95% of the projected proceeds of the .5% healthcare surtax, as required by Section 129.01, Florida Statutes.

1. Primary Care Clinics/Cardiovascular Disease Prevention Clinics
   Allocation: 35%

2. Imaging Facilities
   Allocation: 40% plus any unused allocation from the other categories

3. Hospital Services
   Allocation: 20%

4. Continuity and Coordination of Care/Monitoring and Data Analysis
   Allocation: 5%

EXHIBIT 2

Broward Health Community Health Needs Assessment (CHNA)
Meeting #6: Summary and Prioritization of Needs

November 19, 2021

Prepared By: Michele Rosiere, VP of Programs, Broward Regional Health Planning Council

Leadership Team

Shane Strum

President and Chief Executive Officer

Alex Fernandez

Senior Vice President, Chief Financial Officer

Kathryn Salerno

Director, Community Affairs

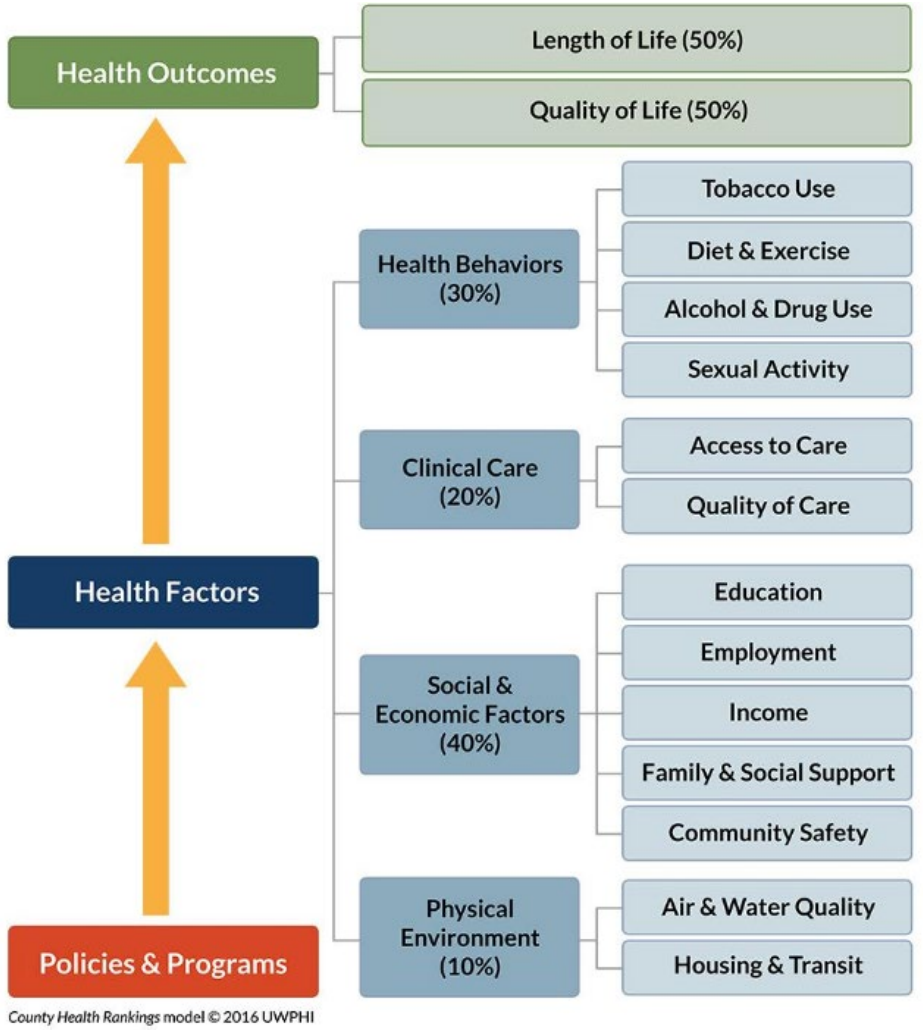
PRESENTATION OVERVIEW

- Summary of Identified Needs
- Discussion
- Priority Ranking of Needs

SOCIAL DETERMINANTS OF HEALTH (SDOH)

- Social Determinants of Health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Approximately 40% of health outcomes are due to social and economic factors alone.



BROWARD HEALTH®

SOCIAL VULNERABILITY INDEX (SVI)

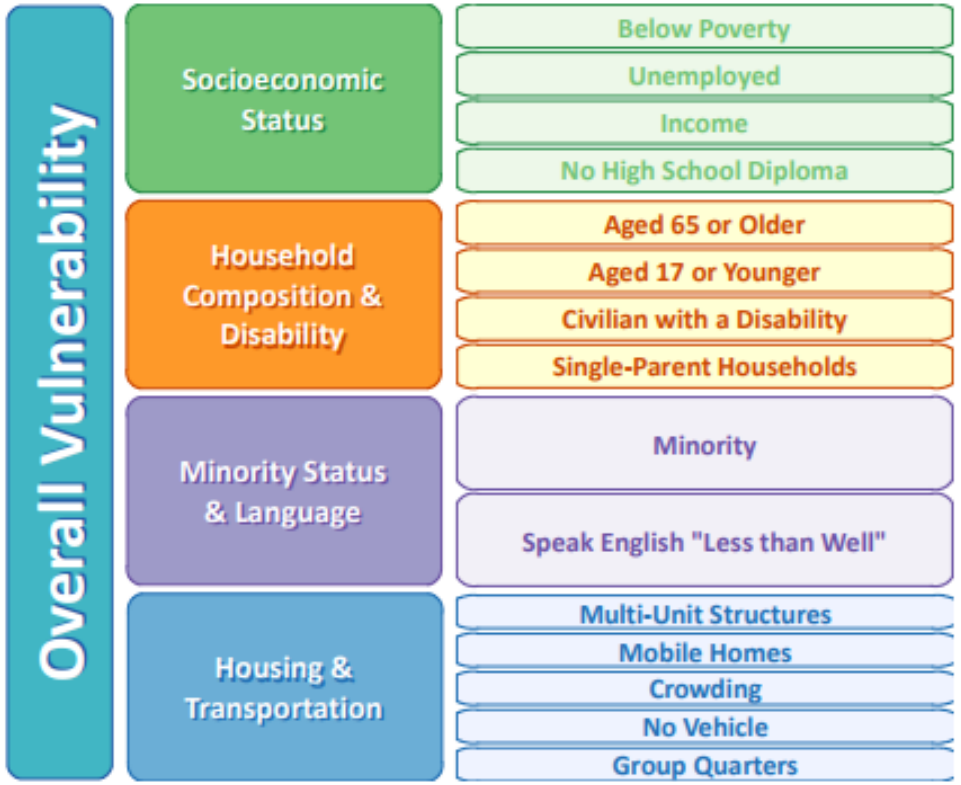
Geospatial Determinants of Health (GDOH) formulates the many and varied geospatial drivers that influence disease prevalence and promote health.

SVI identifies communities that will most likely need support before, during and after a hazardous event such as a pandemic.

The SVI scale goes from zero (0) to one (1), with 1 being the most vulnerable.

A score of 0.58 indicates moderate to high vulnerability.

Broward County's SVI is 0.54.



SVI is comprised of 15-census tract *social and economic factors* within a community organized into four "themes," which are analogous to SDOH:

1. Socioeconomic Status
2. Household Composition & Disability
3. Minority Status & English Proficiency
4. Housing & Transportation

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IDENTIFICATION OF NEEDS

- Based on the quantitative and qualitative data collected throughout the CHNA process, an initial list of identified needs was developed.
- By adopting the Johns Hopkins Model, the identified needs were separated into two categories, **socioeconomic needs** and **health needs**.
- Where feasible, the identified needs were organized to correspond with Healthy People 2030 categories.
- Next Steps:
  - Review the identified needs.
  - Identify items needing modification (edits, additions and/or deletions).
  - Any modifications by the group to the list of needs will be reflected on the prioritization spreadsheet.

BROWARD HEALTH®

IDENTIFICATION OF PRIORITY NEEDS

SDOH Needs

- **Economic Stability & Food Environment**
  - Access to Healthy Food
  - Food Security
- **Health Care Access**
  - Affordability: Resources to Assist with Expenses
  - Health Communication
  - Healthcare and Insurance Navigation
  - Health Literacy
  - Transportation
  - Undocumented Clients
  - Uninsured/Health Insurance
- **Housing/Homelessness**
- **Linguistically & Culturally Appropriate Care**
  - Culturally Appropriate Care Training
  - Sensitivity & Implicit Bias/Structural Racism
  - Language Barriers
  - LGBTQ+ & Transgender Proficiency
  - Maternal & Infant Mental Health

Health Needs

- **Alzheimer's Disease**
- **Asthma**
- **Behavioral Health**
  - Social/Emotional
  - Mental Health
  - Substance Abuse
  - Domestic Violence
- **Cancer**
- **Diabetes/Obesity**
- **Heart Disease & Stroke**
- **HIV/AIDS**
- **Maternal & Infant Health**
  - Prenatal Care
  - Infant & Maternal Deaths
- **Sickle Cell Disease**

DISCUSSION OF IDENTIFIED NEEDS

- Do any items need modification? Edits? Additions? Deletions?
- Any modifications to the list of needs by the advisory council will be reflected on the prioritization spreadsheet.

SDOH Needs

- **Economic Stability & Food Environment**
  - Access to Healthy Food
  - Food Security
- **Health Care Access**
  - Affordability: Resources to Assist with Expenses
  - Health Communication
  - Healthcare and Insurance Navigation
  - Health Literacy
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  - Undocumented Clients
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- **Maternal & Infant Health**
  - Prenatal Care
  - Infant & Maternal Deaths
- **Sickle Cell Disease**

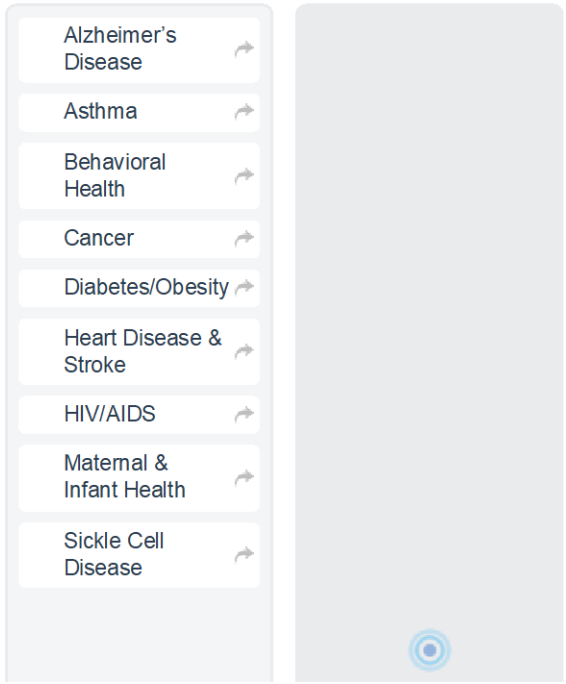
PRIORITIZATION OF NEEDS

2021 Broward Health CHNA: Ranking

2021 Broward Health CHNA Priority Ranking

1. Please review the list of **health needs** identified during the community health needs assessment (CHNA) process and **rank them in priority order** with one being the highest priority. *

Drag items from the left-hand list into the right-hand list to order them.

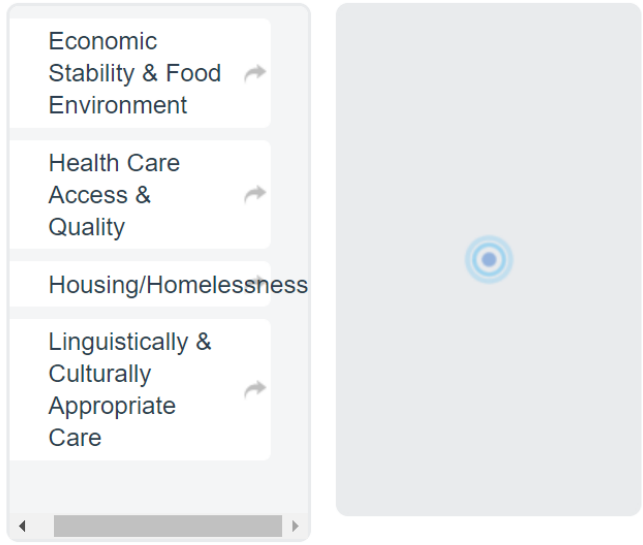


Alchemer Priority Ranking Survey

https://survey.alchemer.com/s3/6620461/2021-Broward-Health-CHNA-Ranking

2. Please review the list of needs related to Social Determinants of Health (SDOH) identified through the CHNA process and rank each in order of priority. *

Drag items from the left-hand list into the right-hand list to order them.



Submit

BROWARD HEALTH®

NEXT STEPS

- **Thank you!**

- Complete the compendium of findings from the CHNA process.
- Develop an implementation plan in partnership with community members like you!
  - Please reach out to Kathy Salerno (ksalerno@browardhealth.org) via email if interested in collaborating!
- Present the prioritization of needs and implementation plan to the North Broward Hospital District Board of Commissioners.
- Disseminate the approved CHNA compendium and implementation plan to the community.

Memorial Healthcare System

2021 - 2024
Community Health Needs Assessment
Annual Update

2021- 2024 Prioritizing the Needs

Data Source

Qualitative:
- ✓ Focus Groups
- ✓ Key Informants

Quantitative:
- ✓ US Bureau of the Census
- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

Qualitative:
- ✓ *Focus Groups*
- ✓ *Key Informants*

Quantitative:
- ✓ *BRHPC Health Data Warehouse*
- ✓ *Florida Charts*

Qualitative:
- ✓ Focus Groups
- ✓ Key Informants

Quantitative:
- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

Qualitative:
- ✓ Focus Groups

Quantitative:
- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

Access to Care

Re-engage community to resume control of their health for routine care and preventative screening
Expand Memorial healthcare services & increase Community Awareness
Continue to expand telehealth and digital services
Increase access to legal and navigation services

Preventive Care

Reduce the use of vaping focus on vulnerable, and at-risk populations including adolescents
Increase Community Awareness of Mental Health and Substance Abuse Program service options

Community Health Education

- ***Improve Quality of life, promote self-care management, and increase preventative screenings***
- ***Reduce the incidence of low birthweight and negative birth outcomes***

Quality of Care

- ***Address race and health equity as it relates to the patient perception of receiving quality care***
- ***Specific focus on health equity by integrating participatory research regarding race and implicit bias***
- ***Implement strategies identified as part of the 2021 MHS Diversity & Inclusion Plan***

Memorial Healthcare System

Re-engage community to resume control of their health for routine care and preventative screening

YOUR SAFETY FIRST

All staff members are required to wear masks at all times.

It must cover your NOSE and MOUTH.

Memorial Primary Care

Thank You for your understanding and cooperation.

Live Your Best Year!

Schedule your wellness visit with us today.

At **Memorial Primary Care**, helping you live your healthiest life is our priority. With your Medicare covered yearly Wellness Visit we can help you get the quality of care you deserve and desire in your golden years.

At the yearly wellness visit we will:

- **Review your current health, medical history and risk factors**
- **Develop a personalized plan to stay healthy**
- **Discuss your wishes for your health, now and in the future**
- **Focus on your social and mental well-being**

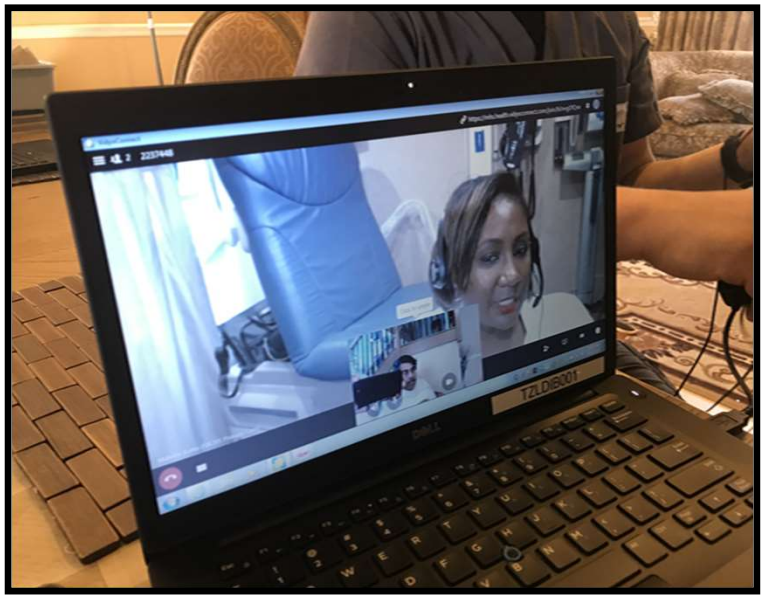
*The wellness visit is not the same as a routine office visit or physical exam. Please mention **yearly wellness visit** when scheduling.*

Memorial Primary Care

Call us today to schedule your appointment:

954-276-5552

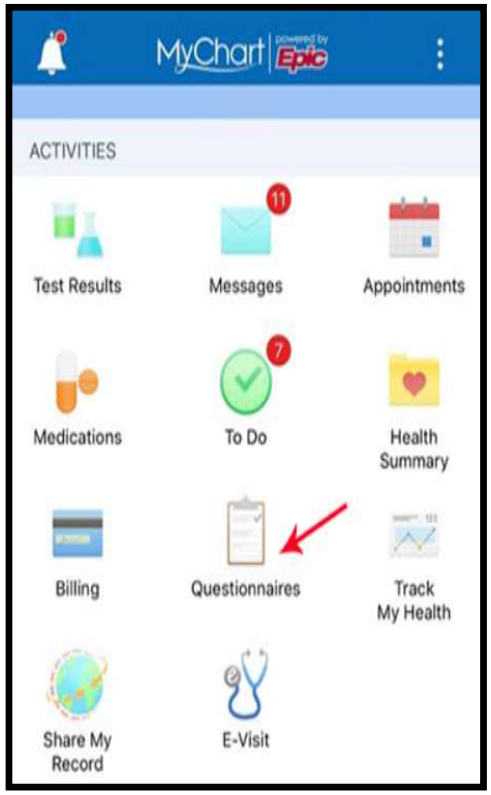
Digital Engagement Personal Touch

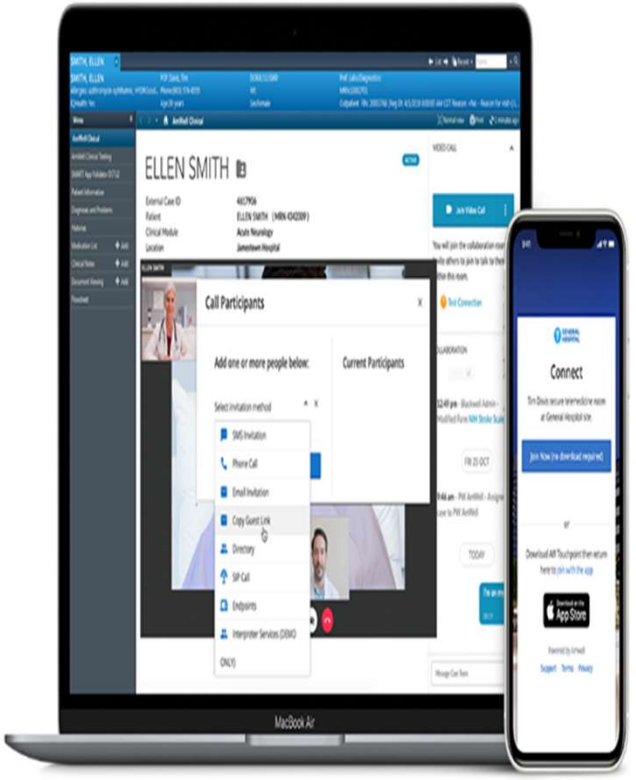


2022- CYS Completed over 1,200 Telehealth Visits

Digital Platforms

84% Active MyChart





Simple Video Connection

Connect with patients or care teams for virtual visits with just one click in Millennium. Amwell Connect EHR generates a simple invitation via SMS or email so that recipients can connect without needing to log in.

[Digital Health – Moving Health Forward with Memorial Healthcare System - YouTube]

Expand Memorial healthcare services & increase Community Awareness

NEW

Aventura
20803 Biscayne Boulevard, Suite 201
Aventura, Florida 33180
954-276-5552

Dania Beach
140-A South Federal Highway
Dania Beach, FL 33004
954-922-7606

Hallandale Beach
1750 E. Hallandale Beach Blvd
Hallandale Beach, FL 33009
954-276-9700

NEW

East Hollywood
3700 Johnson Street
Hollywood, FL 33021
954-265-2550 **Sickle Cell Clinic**

Hollywood
4105 Pembroke Road
Hollywood, FL 33021
954-265-8100

Miramar Medical Office Building
1951 SW 172 Avenue, Suite 210
Miramar, FL 33029
954-538-5670

Miramar
6730 Miramar Parkway
Miramar, FL 33023
954-276-6600

Monarch Lakes
12781 Miramar Parkway, Suite 1-202
Miramar, FL 33027
954-276-1330

West Miramar
10910 Pembroke Road
Miramar, FL 33025
954-276-1300

Pembroke Pines
2217 N. University Drive
Pembroke Pines, FL 33024
954-883-8140

NEW

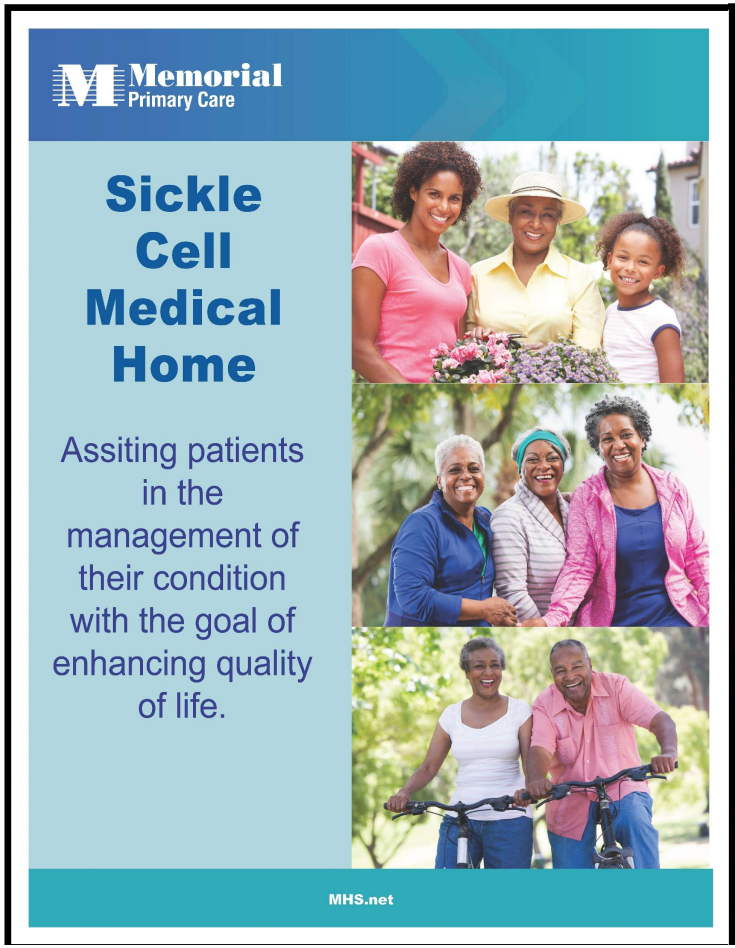
Silver Lakes
17786 SW 2 Street
Pembroke Pines, FL 33029
954-276-1252 **Post Covid Clinic**

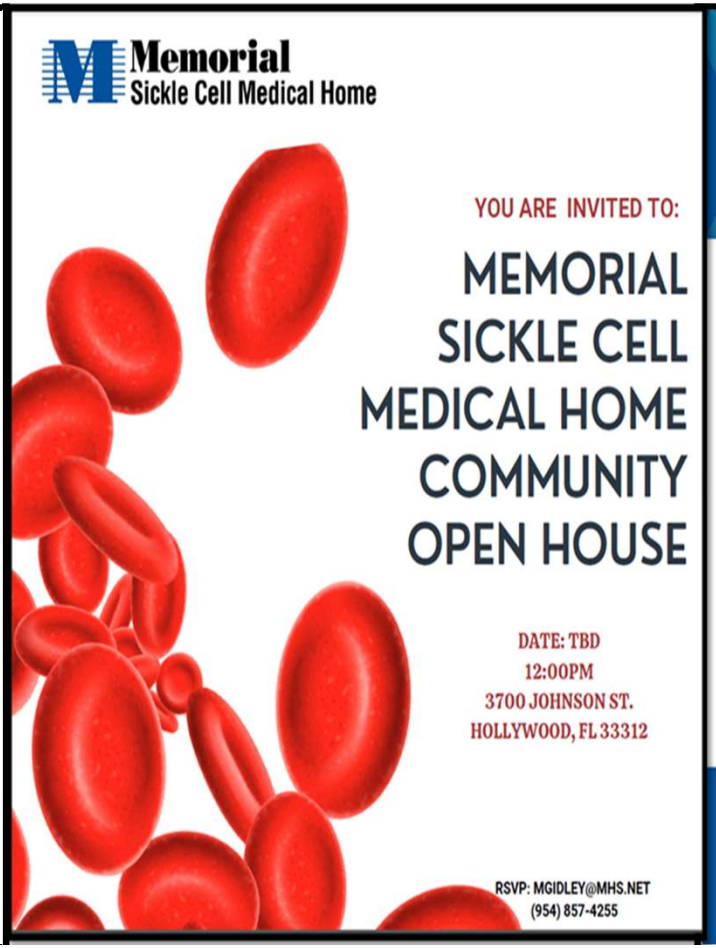
ACCEPTING NEW PATIENTS!
To schedule an appointment call **954-276-5552**

CBS EYE ON HEALTHCARE CHAMPIONS

Video

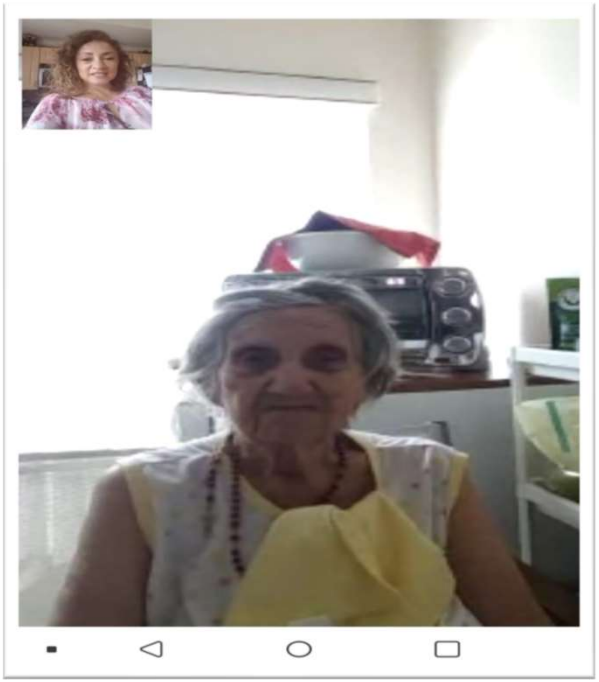
Sickle Cell Medical Home





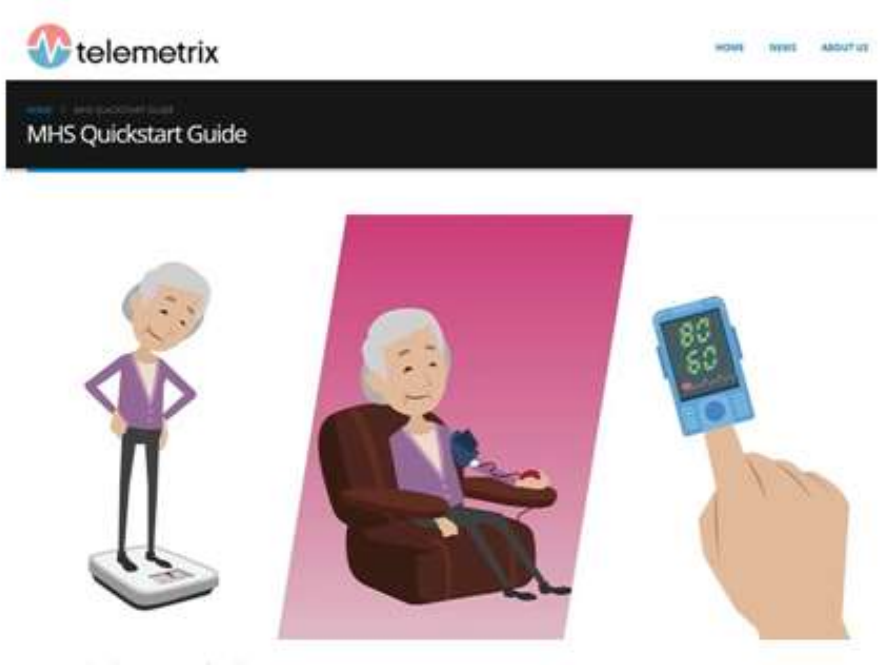
Continue to expand telehealth and digital services

Provide Access to Mobile Devices and Education on Mobile Devices



- Linked 36 Families to Comcast $10/month special
- Provided 217 mobile devices (Smart Phones, Tablets, Laptops)
- Provided education on technology to 219 individuals in underserved communities

Remote Patient Monitoring (RPM)



- **Program implemented in April 2022**
- **99 patients have been enrolled for BP and CHF Monitoring as of Jan 2023**
- **Average length of monitoring is 3 months**

Increased access to legal and navigation services

Medical Legal Aid Partnership

SDOH	Issue	FY20	FY21	FY22	FYTD23 May-Nov
Income	Cash Assistance	7	7	0	1
	Clothing	1	0	2	0
	Consumer/Debt	4	9	9	0
	Food Assistance	13	2	5	1
	Health Insurance	18	15	10	3
	Social Security Disability	32	41	20	16
Housing & Utilities	Homelessness	9	10	18	2
	Housing (Tenant issues	32	32	21	17
	Utilities	5	0	1	0
Education & Employment	Education	3	1	3	0
	Employment/Unemployment	4	10	3	0
Legal Status	Immigration	7	9	3	10
	Veteran Issues	0	0	6	0
Personal & Family	Family Law	15	14	13	1
	HIV/AIDS	0	0	0	0
	Safety/Domestic Violence	1	2	1	5
	Transportation	6	0	4	0
Natural Disaster	*COVID-19 Related Issues	6	31	18	6

490- Total Referrals

41 - Retained/Accepted

35 - Resolved/Closed

274 - Advise Given/Referred outside Recourses for Non-Legal Medical Matters

146- Other legal advice given or facts in case did not rise to the level of a legal matter.

Reduce the use of vaping focus on vulnerable, and at-risk populations including adolescents

Mist Busters: Facts and Fiction Around Vaping

- Memorial Cancer Institute partnered with American Lung Association to host *Mist Busters: Facts and Fiction around Vaping* via Facebook Live
- **Dr. Mark Block**, Chief of Thoracic Surgery Division, went over 4 myths regarding vaping as well as vaping statistics and facts
- Staff from the State of Florida, Virginia, Texas, and Ohio Health Departments joined the live session

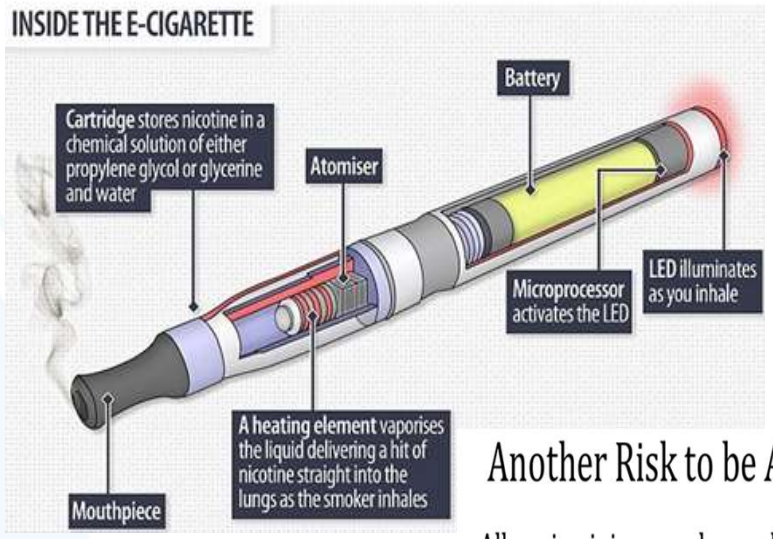
Vaping Outreach and Activities

Educational Workshops

Provided 167 educational workshops

3,318 Youth Attended

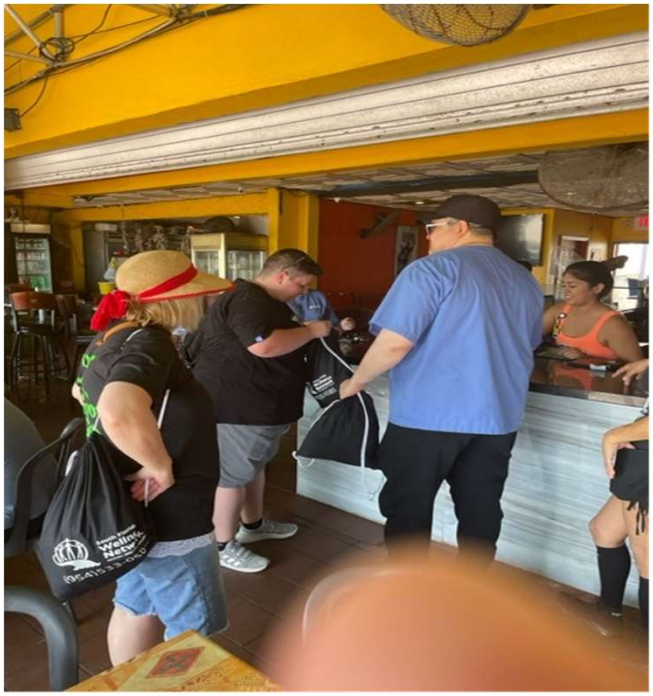
Remote Vaping Education



Another Risk to be Aware of...

- All vaping juices can be modified or switched out to use THC oil
  - THC oil is a concentrated illegal substance
  - This is a FELONY charge
  - The smallest trace of THC will still be grounds for felony

Increase Community Awareness of Mental Health and Substance Abuse Program service options



Hollywood Beach- Narcan Education & Kit Distribution

Improve Quality of life, promote self-care management, and increase preventative screenings

LivWell Program

Improve the health status of patients with chronic conditions including:

- Diabetes
- Overweight
- High blood pressure
- Heart diseases
- Behavioral health

Number Enrolled: 144

Target Population:
Uninsured Emergency Dept. frequent users

LivWell – Practical Medicine

Support Group with Community Partners

Provided 27 Support Groups
239 Attendees

Topics include:

- Pre-diabetes
- Applying for benefits
- How to use 211
- Family Success Center
- Nutrition workshops
- Hurricane Preparedness

BLACK MATERNAL HEALTH OUTCOMES

BLACK MATERNAL HEALTH STATISTICS 2022	HYPERTENSION	HIGH RISK HEMORRHAGE
Total Number of Eligible Pregnant Women	65	11
Number of Women Educated on Pregnancy and Post Partum Warning Signs since May 16, 2022	65	11
Number of Deliveries	51	10
Women who transmitted BP readings timely, during post partum period (Day 1-14)	37	N/A
Number of BP monitors provided to those without a monitor	43	N/A
Scheduled Post-Partum Appointment. (HEDIS Metric- Timeliness to Post-partum care w/l (7-84 days)	45	8
Completed Post-Partum Appointment. (HEDIS Metric Timeliness to Post-partum care (7-84 days)	43 8 - have upcoming appointments	8

Dedicated to Improving Black Maternal Outcomes at MHS:

Dr. Tim Desantis, Chief OBGYN
Dr. Todra Anderson, MHM CMP
Dr. Laurie Scott, Maternal Fetal Medicine
Dr. Randy Katz, Regional ED Director MHS
Dr. Jennifer Goldman, Chief MPC
Laurie De Sabatino, OB APRN
Melida Akiti, VP Ambulatory Services MPC
Dionne Proulx, Admin Director MPC
Jennifer Reilly-Miller, DON MPC
Tammy Reese, Director Care Coordination MPC
Mary Roberts, Director MHW Family Birthplace
Gessy Targete, Director MHM Family Birthplace
Jane Mccarthy, Director MRH Family Birthplace
Monica King, CEO Healthy Start
Samantha Silver, Healthy Start
Dorothy Stirrup, Healthy Start
Maria Mendez, Healthy Start Team Leader
Tim Curtin, Executive Director CYS
Amanda Lopez, Team Leader CYS
Yani Quintana, Team Leader CYS

*Sponsor: Essential Hospitals Institute & CVS Foundation

https://www.youtube.com/watch?v=5mNh9-k7q1w

Address race and health equity as it relates to the patient perception of receiving quality care

Trusted Leaders in underserved communities

KOINONIA

Community Enhancement Collaboration, Inc.
Our Hands • Our Home • Our Heart
We're in the Heart of the Community

ESTABLISHED IN 1908
ST. RUTH MISSIONARY BAPTIST CHURCH

POLICE PAL ATHLETIC LEAGUE

BrowardUP™
ACHIEVE UNLIMITED POTENTIAL

Community Stakeholders addressing SDOH

- 211 Broward
- Area Agency on Aging of Broward County
- ARC Broward
- Broward Behavioral Health Coalition
- Broward Education Foundation
- Broward Regional Health Planning Council
- Children's Services Council of Broward County
- City of West Park
- Community Care Plan
- Community Enhancement Collaboration
- Community Foundation of Broward
- Coordinating Council of Broward
- Department of Children and Families
- Florida Association on Infant Mental Health
- Florida Dept. of Health in Broward County
- Frederick A. DeLuca Foundation
- Health Foundation of South Florida
- Healthy Start Coalition of Broward County
- Hispanic Unity of Florida
- Legal Aid of Broward County
- Meals On Wheels
- Mobile School Pantry
- National Alliance on Mental Illness
- United Families for Children's Mental Health
- Urban Health Partnership
- United Way of Broward County

Implement strategies identified as part of the MHS Diversity, Equity and Inclusion Plan

Looking Forward – 2023

MHS will be a market leader by infusing key DEI strategies that ensures equitable outcomes for all stakeholders.

DEI creates the spaces where everyone belongs.

Memorial Primary Care

MHS.net/PrimaryCare

COMMUNITY RELATIONS COMMITTEE

FEBRUARY 2023

Memorial Primary Care

IMPACTING THE SOUTH BROWARD COMMUNITY

"ONE CITY AT A TIME"

ACTION PLAN

- Target each Municipality with a high Indicator of need.
- Utilize the Memorial Mobile Van and the HITS Team for Preventative Care and Eligibility.
- Remain in the target community daily for four weeks and work with community partners to support Social Determinants of Health (SDOH) needs and close the gap.
- Develop best practice indicators for each City according to data provided by Broward Regional Planning Council and Memorial Clinical Effectiveness database.
- Work with the League of Cities to identify the Mayor's healthcare initiatives and include them in our plans.
- Work with Humana, Florida Blue, Community Care Plan, and other payors on cross-referencing their Population Health strategy with the One City At A Time initiative.
- Collaborate with funders as a funding stream for Community Base Organizations collaboratives.

METHODOLOGY FOR MATERNAL HEALTH OBJECTIVES:

Memorial Primary Care

Using a maternal mortality ratio indicates the likelihood of a pregnant woman dying of maternal causes. It is calculated by dividing the number of maternal deaths in a calendar year by the number of live births registered for the same period and is presented as a rate per 100,000 live births. The number of live births used in the denominator approximates the population of pregnant women who are at risk of maternal death.

A. Targets to:
   - Reduce maternal death rates by half
   - Reduce low-risk cesarean deliveries by 25%
   - Achieve blood pressure control among 80% of the women of childbearing age

B. The plan calls for:
   - Improving prevention and treatment
   - Prioritizing quality improvement
   - Improving the health of women before and after giving birth
   - Improving data that helps Americans make healthy choices for themselves and their families, and discuss evidence-based, community-level interventions that can make being physically active the easy choice in all the places where people live, learn, work, and play. The “Physical Activity Guidelines for Americans” will be used to assess outcomes

CHILDBIRTH OBJECTIVES:

Memorial Primary Care

Despite advances in medical research and care, there are significant disparities in maternal health and infant birth and health outcomes. Access to prenatal care and education can dramatically improve birth and health outcomes for moms and their babies, but women who are uninsured (or underinsured) often miss out on these critical services.

Infants born before 37 weeks of gestation have a higher risk of infections, developmental problems, breathing problems, and even death. Preterm births are more common in some racial/ethnic groups. Strategies to reduce preterm births include promoting adequate birth spacing, helping women quit smoking, addressing SDOH and providing high-quality medical care for women during pregnancy.

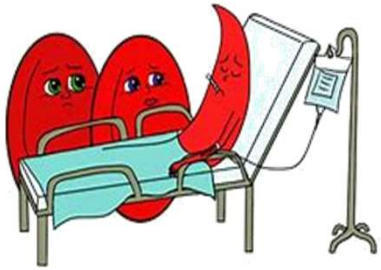
The total preterm birth rate is calculated as the number of births delivered at less than 37 completed weeks of gestation per 100 total births, based on the obstetric estimate of gestation.

METHODOLOGY FOR SICKLE CELL OBJECTIVES:

Memorial Primary Care

Sickle cell disease is a lifelong, inherited disorder which can cause several complications throughout an individual's life. It may cause a huge burden on both the patient and their family, including frequent visits to healthcare facilities. The illness causes not just physical complications such as painful crises and strokes, but may have many other effects such as depression, poor quality of life, coping issues and poor family relationships. When people with a chronic illness have better understanding about their illness, they manage their illness better and improve their quality of life. We wish to compare effects of different interventions as well as individual interventions to no intervention.

The Cochrane Collaborative found that educational programs can improve knowledge and understanding of sickle cell disease and decrease depression in people who have sickle cell disease. Evidenced based educational materials and quiz about sickle cell will be used to evaluate improved knowledge of sickle cell disease and recognition its related complications.



METHODOLOGY FOR HEART DISEASE & STROKE:

Memorial Primary Care

The risk of having or dying from heart disease **varies by race**. Blacks, and People of Color are more at risk for complications from heart disease than white Americans. This includes a higher death rate.

The Community Preventive Services Task Force (CPSTF) recommends the following models of care:

- Screening and health education
- Outreach, enrollment, and information
- Team-based care
- Patient navigation
- Community organizers

Targeted screening of ethnic minorities helps tackle heart disease, stroke, and health inequalities. Targeting screening at deprived areas is a more cost-effective way of identifying people in ethnic minority groups at high risk of cardiovascular disease (CVD) than mass screening and may help to reduce health inequalities. Heart disease screening and health education will be used to evaluate the outcomes for this objective.

METHODOLOGY FOR OVERWEIGHT & OBESE OBJECTIVES:

Memorial Primary Care

Many adults in the United States have obesity, which is linked to chronic diseases like type 2 diabetes, cardiovascular disease, and several types of cancer. Obesity-related stigma and discrimination can also lead to health problems. Evidence suggests that intensive behavioral interventions that use more than 1 strategy — like group sessions and changes in both diet and physical activity — are an effective way to address obesity. Both strategies will be used to evaluate outcomes for the objective. When these interventions are implemented in minority or underserved communities, they can improve health, reduce health disparities, and enhance health equity. Economic evidence also indicates these interventions are cost-effective.

METHODOLOGY FOR LACK OF INSURANCE OBJECTIVES:

Memorial Primary Care

About 1 in 10 people in the United States do not have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses. Interventions to increase access to health care professionals and improve communication. In person or remotely visit can help more people get the care they need.

Interventions to increase access for an annual primary care check-up, and improve communication will include both, In-person or remotely visits to help more people get the care they need. Strategies to evaluate outcomes for the objective include a grass roots approach to provide primary care check-up by binging healthcare to targeted areas with the highest healthcare disparities.

REFERENCES:

Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030.*U.S. Department of Health & Human Services. Reduce maternal deaths — MICH-04 - Healthy People 2030 | health.gov

Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030.*U.S. Department of Health & Human Services. National Vital Statistics System - Mortality (NVSS-M) - Healthy People 2030 | health.gov

Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030.*U.S. Department of Health & Human Services. Data Sources and Methods - Healthy People 2030 | health.gov

MATERNAL HEALTH/CHILDBIRTH OBJECTIVES	MEASURE DEFINITION	BASELINE DATA-BROWARD COUNTY OR MHS	MPC/MHS TARGET	HEALTHY PEOPLE 2030 BASELINE DATA	HEALTHY PEOPLE 2030 TARGET
Reduce Maternal Deaths	Numerator: Number of female deaths due to obstetric causes (ICD-10 codes: A34, O00-O95, O98-O99) while pregnant or within 42 days of being pregnant Denominator: Number of live births	TBD	__2__% reduction from baseline TBD	23.8 Deaths per 100,000 live births	15.7 per 100,000
Reduce the number of Pre-term Births	Numerator: Number of Infants Born before 37 Weeks Gestation Denominator: Number of Live Births	TBD	1% reduction over baseline	10.0%	9.4%

SICKLE CELL OBJECTIVE	MEASURE DEFINITION	BASELINE DATA-BROWARD COUNTY OR MHS	MPC/MHS TARGET	HEALTHY PEOPLE 2030 BASELINE DATA	HEALTHY PEOPLE 2030 TARGET
Interventions for Patients to Improve Knowledge of Sickle Cell Disease and Recognition of its Related Complications	Numerator: Number of patients who established care with the Sickle Cell Medical Home who showed improvement from the Pre-Educational Test Denominator: Number of patients who established care with the Sickle Cell Medical Home and completed Pre & Post Educational test on recognition of signs and symptoms of disease-related morbidity, adherence to treatment and healthcare utilization in patients with Sickle Cell Disease	MHS Baseline-Pre-Educational Test Score	10% increase over Baseline	Clinical Trials 48% demonstrated knowledge pre-education	Improve over baseline

HEART DISEASE & STROKE	MEASURE DEFINITION	BASELINE DATA-BROWARD COUNTY OR MHS	MPC/MHS TARGET	HEALTHY PEOPLE 2030 BASELINE DATA	HEALTHY PEOPLE 2030TARGET
Reduce Prevalence of Heart Disease in South Broward	Numerator: Number of residents who received Heart Disease screening and health education in minority and underserved communities Denominator: Number of minority and underserved communities targeted for intervention	2021 South Broward Rate: 12% Broward County: 10% State FL: 7.2% US: 6.1%	Reduce South Broward rate over prior year PRC Needs Assessment data	N/A	N/A

OVERWEIGHT & OBESE	MEASURE DEFINITION	BASELINE DATA-BROWARD COUNTY OR MHS	MPC/MHS TARGET	HEALTHY PEOPLE 2030 BASELINE DATA	HEALTHY PEOPLE 2030 TARGET
Reduce Prevalence of Obesity in South Broward to improve health, reduce health disparities, and enhance health equity	Numerator: Number of Overweight and obese residents who received health education on changes in both diet and physical activity in minority and underserved communities Denominator: Number of Overweight and obese minority and underserved residents with a BMI >30	2021 South Broward Rate: 37.1% Broward County: 28.3% State FL: 27% US: 31.3%	Reduce South Broward rate over prior year PRC Needs Assessment data	N/A	N/A

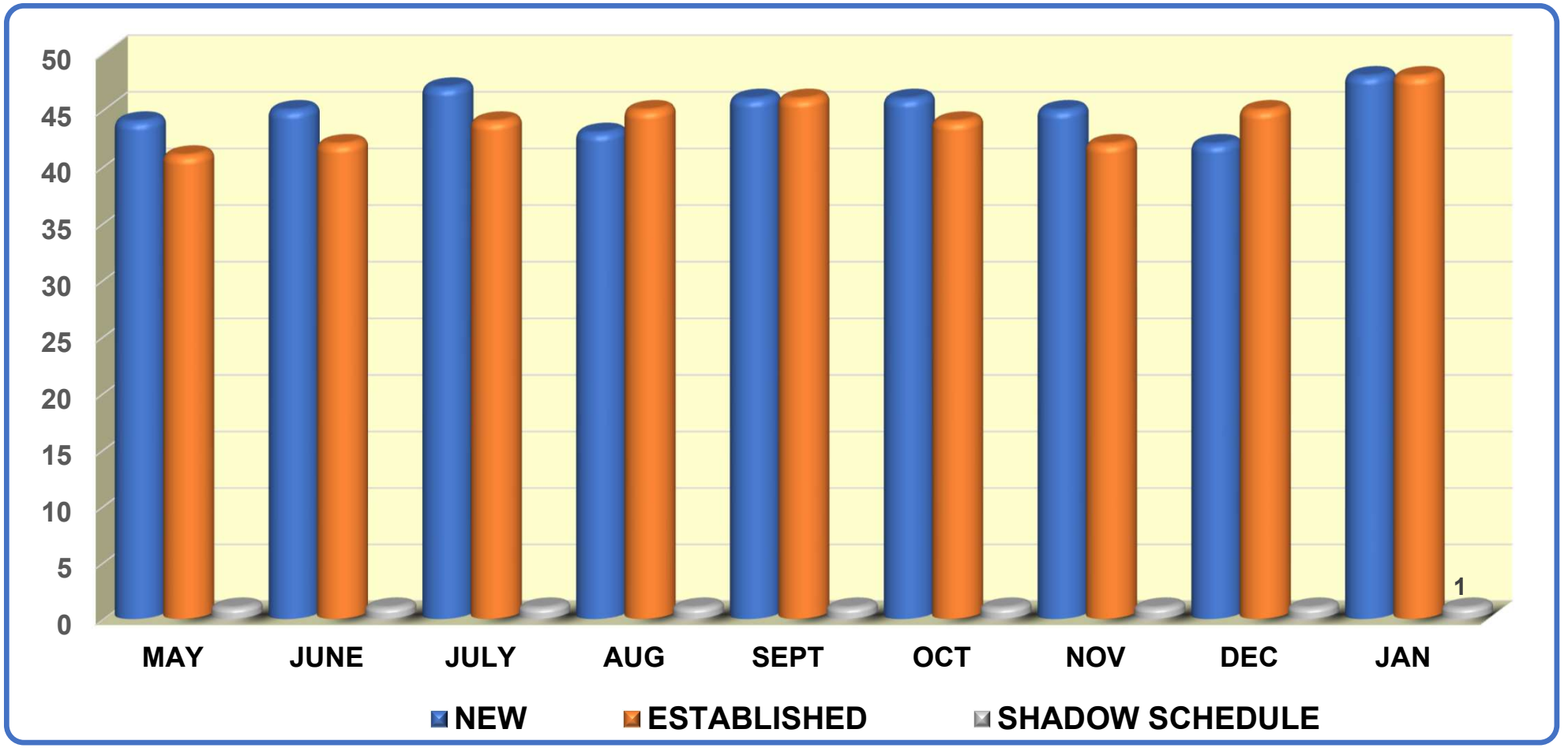
LACK OF HEALTHCARE INSURANCE	MEASURE DEFINITION	BASELINE DATA-BROWARD COUNTY OR MHS	MPC/MHS TARGET	HEALTHY PEOPLE 2030 BASELINE DATA	HEALTHY PEOPLE 2030 TARGET
Increase the proportion of people with health insurance	Numerator: Number of persons under 65 years who report coverage by any type of public or private health insurance Denominator: Number of persons under 65 years	2021 South Broward rate for lack of healthcare insurance is: 9.2%	1% decrease from 2023 South Broward Rate of 9.2%	2019 - 12%	7.6%
Increase the number of people who have visited a Physician for a checkup in past year care	Numerator: Number of persons who visited a physician for a checkup Denominator: Number of persons who did not visit a physician for a checkup	2021 South Broward Rate: 62.8% Broward County: 63.1% State FL: 80.4% US: 70.5%	Increase South Broward rate over prior year PRC Needs Assessment data	N/A	N/A

Memorial Primary Care

VALUABLE BASE

AVERAGE NEXT AVAILABLE APPOINTMENT DAYS – FY 2023

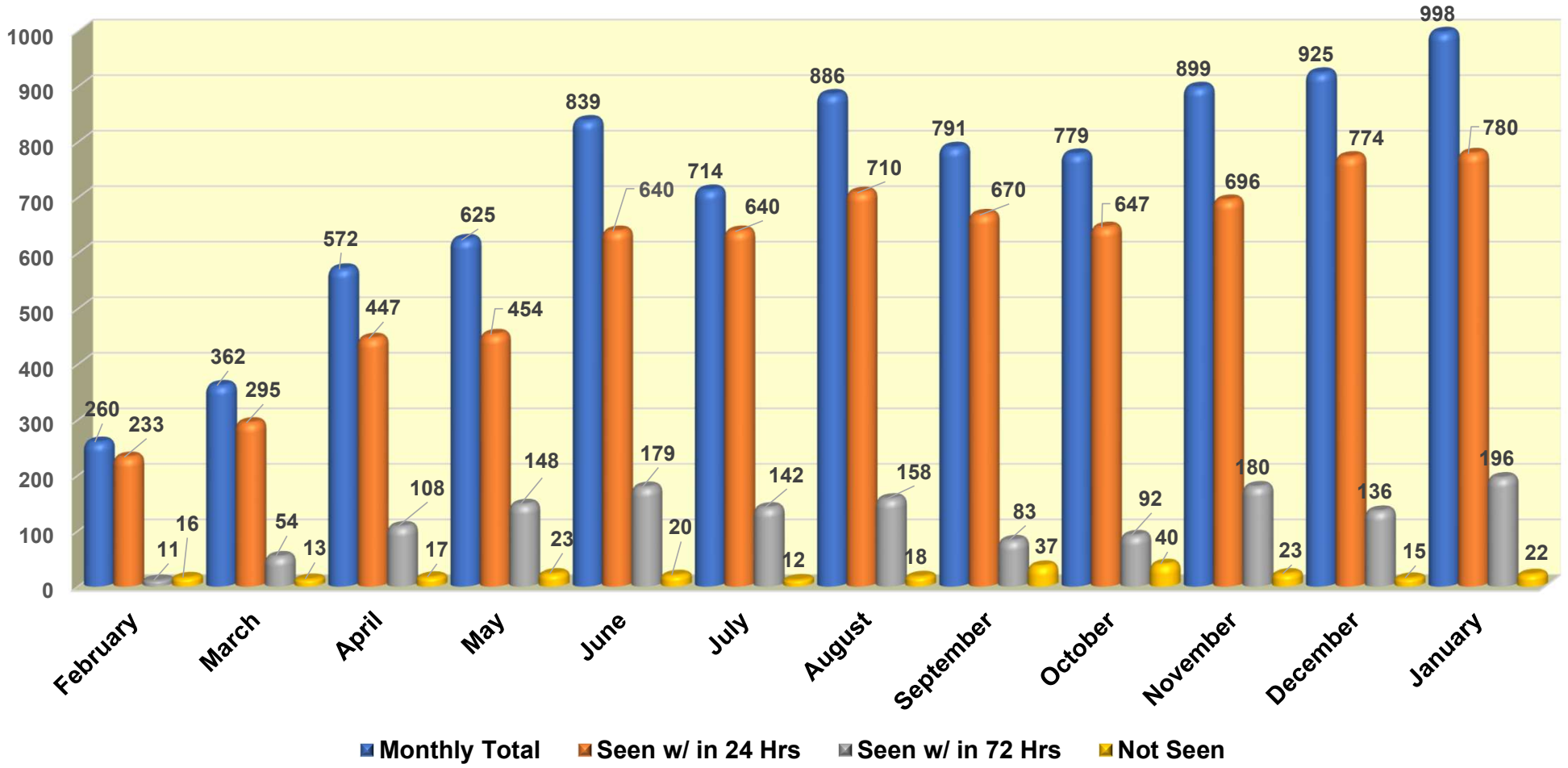
Memorial Primary Care



PATIENT EXPERIENCE

Memorial Primary Care

Shadow Schedule Stats



COST

Memorial Primary Care

HOSPITAL CONTRIBUTION MARGIN

Reporting - FY2023 November YTD

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023P
Insured Membership	11,545	16,443	22,702	25,975	28,161	31,147	29,108	33,623
Uninsured Membership	8,383	7,148	6,287	6,651	6,895	3,974	2,852	2,607
Loss from Practice Operations	$ (14,284,641)	$ (14,441,594)	$ (9,871,536)	$ (7,826,742)	$ (7,777,771)	$ (6,710,838)	$ (5,701,620)	$ (2,107,856)

Hospital Direct Margin - Insured	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023P
Inpatient	$ 4,251,891	$ 5,471,001	$ 8,833,901	$ 7,311,497	$ 9,608,708	$ 13,535,505	$ 8,480,745	$ 3,495,194
Observation	$ 524,292	$ 911,085	$ 941,313	$ 1,018,257	$ 1,602,463	$ 761,851	$ 553,374	$ 111,854
Emergency	$ 1,198,741	$ 1,216,462	$ 1,352,789	$ 1,282,956	$ 1,325,720	$ 1,050,308	$ 1,183,416	$ 930,365
Outpatient	$ 4,440,310	$ 3,137,644	$ 3,808,900	$ 4,799,372	$ 7,693,231	$ 10,852,364	$ 8,345,577	$ 6,251,726
Total Hospital Direct Margin - Insured	**$ 10,415,234**	**$ 10,736,192**	**$ 14,936,903**	**$ 14,412,082**	**$ 20,230,122**	**$ 26,200,028**	**$ 18,563,112**	**$ 10,789,138**

Hospital Direct Margin - Uninsured	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023P
Inpatient	$ (4,496,987)	$ (4,596,377)	$ (5,090,440)	$ (5,339,946)	$ (6,826,754)	$ (5,358,471)	$ (3,475,313)	$ (3,684,693)
Observation	$ (1,493,282)	$ (1,357,191)	$ (1,125,553)	$ (1,805,106)	$ (2,074,640)	$ (1,065,354)	$ (1,063,131)	$ (1,158,439)
Emergency	$ (846,380)	$ (859,452)	$ (877,222)	$ (951,863)	$ (1,237,914)	$ (833,020)	$ (783,191)	$ (651,699)
Outpatient	$ (5,824,125)	$ (5,297,844)	$ (5,178,465)	$ (5,585,948)	$ (5,591,794)	$ (4,537,504)	$ (3,671,916)	$ (3,428,016)
Total Hospital Direct Margin - Uninsured	**$ (12,660,774)**	**$ (12,110,864)**	**$ (12,271,680)**	**$ (13,682,863)**	**$ (15,731,102)**	**$ (11,794,349)**	**$ (8,993,551)**	**$ (8,922,847)**
Net of Insured vs. Uninsured	**$ (2,245,540)**	**$ (1,374,672)**	**$ 2,665,223**	**$ 729,219**	**$ 4,499,020**	**$ 14,405,679**	**$ 9,569,561**	**$ 1,866,291**

Our Locations

Memorial Primary Care

Aventura
20803 Biscayne Boulevard, Suite 201
Aventura, Florida 33180
954-276-5552

Dania Beach
140-A South Federal Highway
Dania Beach, FL 33004
954-922-7606

Hallandale Beach
1750 E. Hallandale Beach Blvd
Hallandale Beach, FL 33009
954-276-9700

East Hollywood
3700 Johnson Street
Hollywood, FL 33021
954-265-2550

Hollywood
4105 Pembroke Road
Hollywood, FL 33021
954-265-8100

Miramar Medical Office Building
1951 SW 172 Avenue, Suite 210
Miramar, FL 33029
954-538-5670

Miramar
6730 Miramar Parkway
Miramar, FL 33023
954-276-6600

Monarch Lakes
12781 Miramar Parkway, Suite 1-202
Miramar, FL 33027
954-276-1330

West Miramar
10910 Pembroke Road
Miramar, FL 33025
954-276-1300

Pembroke Pines
2217 N. University Drive
Pembroke Pines, FL 33024
954-883-8140

Silver Lakes
17786 SW 2 Street
Pembroke Pines, FL 33029
954-276-1252

COMING SOON

****PLANTATION***
1000 S. PINES ISLAND RD/STE A-180, PLANTATION
****MIAMI GARDENS/COUNTRY CLUB***
8665 AND 8649 NW 186 STREET, HIALEAH
****WESTON***
17130 ROYAL PALM BLVD/STE 1&2, WESTON

ACCEPTING NEW PATIENTS!

To schedule an appointment call **954-276-5552**

MEMORIAL
Health Forward

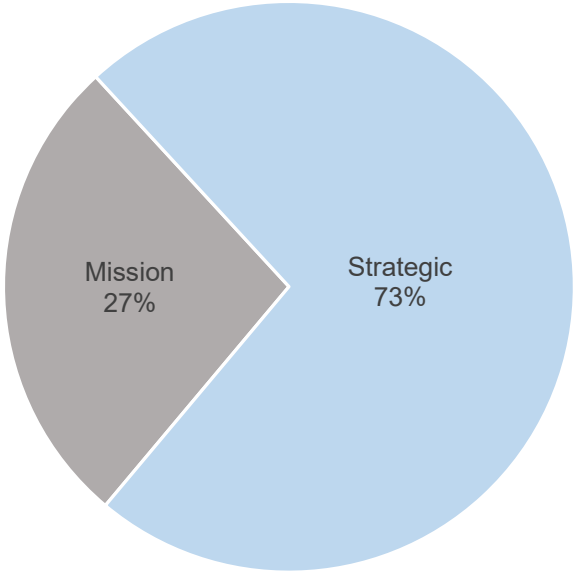
Memorial Healthcare System | Marketing and Corporate Communications

Community Relations

FY23 Q3 | November 2022 January 2023

Community Relations

		Activities	Attendees
	• **Sponsorships & Events:** • Strategic and Mission • Service line booths, health education, In house special events	96	38,761
	• **Corporate Wellness:** • Employee prevention, health education, lectures & screenings	6	368
	• **Speakers Bureau Engagements:** • Community-based & civic organizations	14	30,642
	TOTAL FY23 Q3	**203**	**100,850**

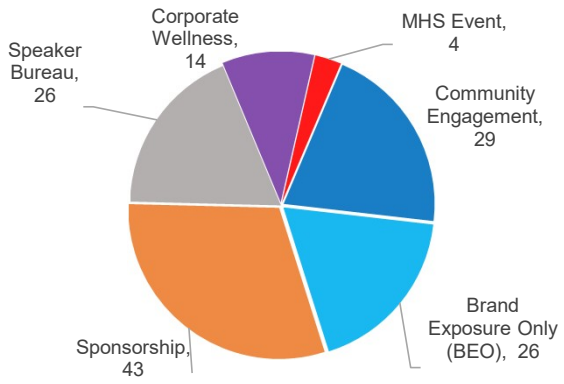


- **56 SDoH & DEI activities**
- **150 Service Line & Sponsor Events**

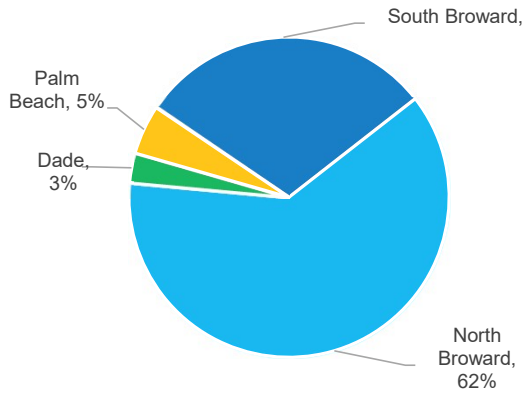
Community Relations

Adult Services Community Engagement – FY23 Q3

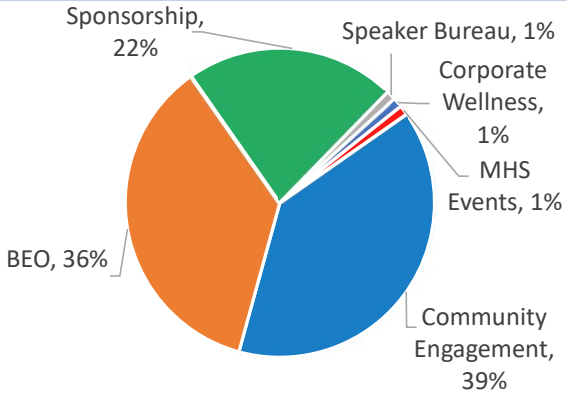
142 Events by Program



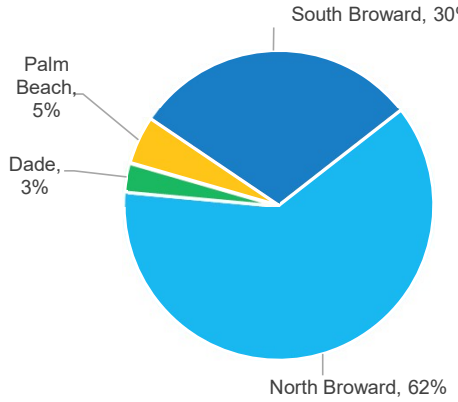
138,420 Strategic Attendees by County



138,420 Attendees by Program



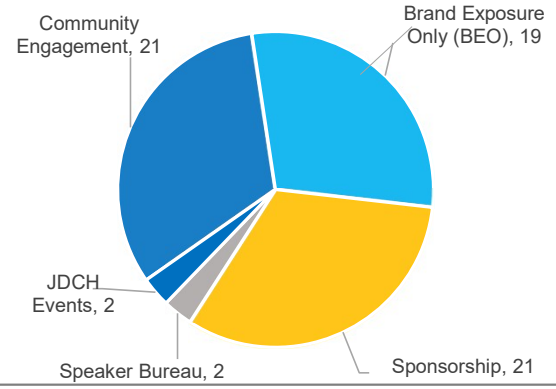
14,804 Mission Attendees by County



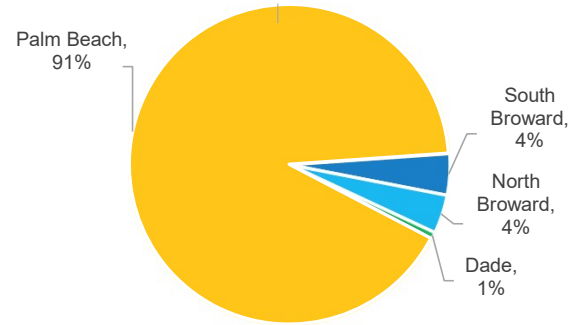
Community Relations | FY23 Q3 Summary

JDCH Community Engagement – FY23 Q3

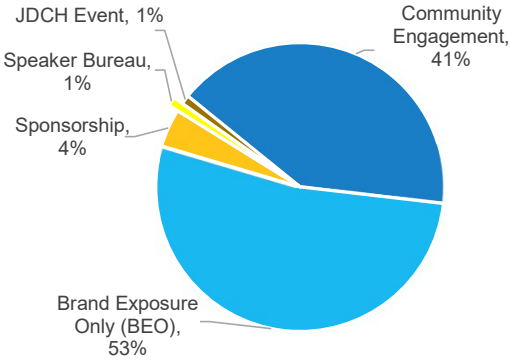
65 Events by Program



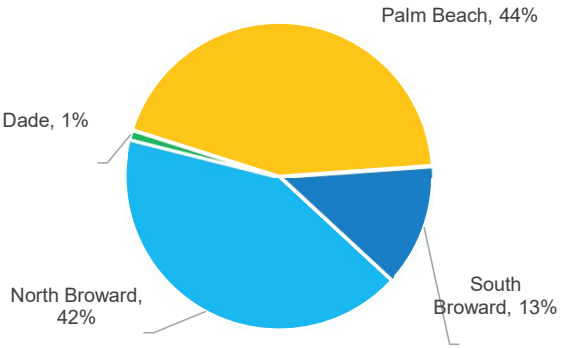
122,909 Strategic Attendees by County



199,644 Attendees by Program



76,735 Mission Attendees by County



National Kidney Foundation's Fort Lauderdale Kidney Walk

- The Memorial Transplant Team raised awareness and funds for transplant families.
- **Dr. Linda Chen**, Surgical Director, Living Donor & Pediatric Abdominal Transplant Program, spoke on the importance of awareness and support
- Julie, the wife of **Mack Barnes,** expressed gratitude to the Memorial Transplant team for saving her husband's life. She joined the MTI team in encouraging the community to, *"Share Your Spare!"*

Crohn's & Colitis Winter Wonderland Luncheon

- **Dr. Jacqueline Larson**, Pediatric Gastroenterologist, was this year's honoree for her amazing work in South Florida

- Our partnership helps advance research and patient education/ support

- Dr. Larson gained two new patients

American Lung Assn: Facts/Fiction On Vaping

- **Dr. Mark Block**, Chief of Thoracic Surgery Division, addressed common myths:
  - Vaping...
    - is just flavored water vapor
    - helps smokers quit
    - is safer than smoking
    - doesn't lead to smoking
- National forum & attendance
- Ties to the Community Health Needs Assessment initiatives

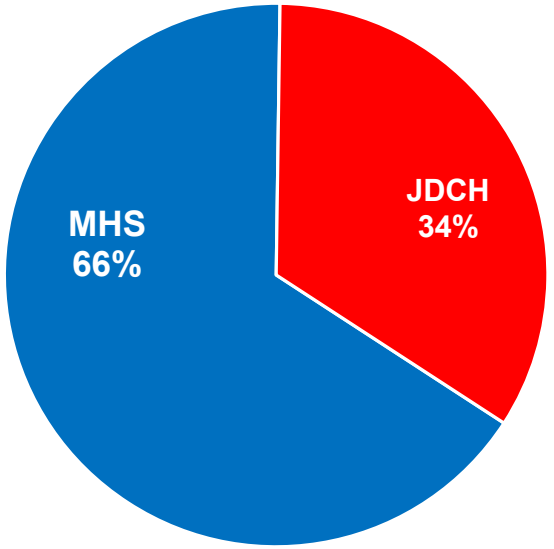
MHS Corporate Wellness

ORGANIZATION	VISITS	TOPIC	SPEAKER(S)	# STAFF	HEALTH PLAN	COUNTY
American Postal Workers Union, Miami Local 172	1	Mental Health	Gretchen Haddad, Clinical Therapist	2,000	APWU Health Plan	Dade
Bank United	1	Gut Health	Ashley Paelez, Reg. Dietician	1,500	United Healthcare	Dade
Broward College	3	Health Fair	None	5,000	Cigna	S. Broward
City of Hollywood	1	Nutrition	Jeneene Connelly & Rebeca Stevenson, Bariatric Dietitians	1,494	Capital Health, Cigna	S. Broward
Gulfstream Park	1	Primary Care	Jacqueline Kilmer, Educator Community Health Resource	699	United Healthcare	S. Broward
Town of Davie	1	Health Fair	None	750	United Healthcare	S. Broward
Bank of America	1	Integrative Medicine	Dr. Ashwin Mehta, Medical Director	2,025	Blue Cross & Blue Shield, Aetna, United	N. Broward
Broward Center for The Performing Arts	1	Breast Cancer; Integrative Medicine	Dr. Joshua Park, Acupuncturist	72	Florida Blue	N. Broward
City Furniture	1	Diabetes	Sonia Angel, Liaison Diabètes Nutrition	3,000	Aetna	N. Broward
City of Fort Lauderdale	2	Health and Wellness	Jackie Gavino, Clinical Exercise Physiologist	1,600	Cigna	N. Broward
South Florida Water Management District	1	Cancer Prevention through Nutrition	Katie Shelton, Clinical Dietitian	1,000	Cigna	Palm Beach

Total Staff: 19,140

Mission: SDoH and DEI Activity

SDoH CATEGORIES	
• Economic Stability	11
• Education, Access & Quality	17
• Health Care Access & Quality	3
• Neighborhood & Built Community	10
• Social & Community Context	15
DEI CATEGORIES	
• Ethnicity	5
• Gender	6
• Disabilities	6
• Veterans	2
• Vulnerable Community	37



10th Annual Miss ARC Broward Pageant

ARC provides skills for children and adults with developmental disabilities to develop/thrive through 21 programs and residential services. They work with the community to change how people with developmental disabilities are embraced and included.

- The Pageant is a heartwarming and inspiring event for young women 6 – 17
- Contestants participate in a supportive pageant environment providing core tools for success such as confidence and teamwork.
- Sponsorship support includes MHS Board & DEI committee participation

30th Annual Harvest Drive

Founded in 1992 in Weston, Harvest Drive started at one school with 25 turkeys and now feeds 2,400 families with the help of 200 Broward public schools

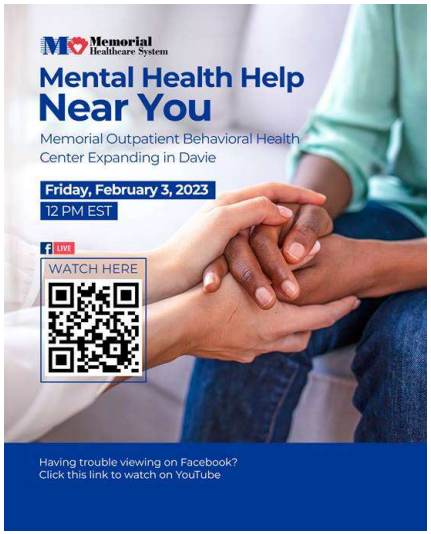
- As a result of the pandemic, Harvest Drive transitioned from a mostly seasonal to a year-round operation
- School social workers provides Harvest Drive with lists of families in need, and they do the rest to help in anyway they can
- MHS employees volunteering during holiday season

MHS Leadership in the Community

Turkey/Holiday Meal Community Distribution with Board of Commissioners

Outpatient Behavioral Health Center Opening – January 2023

Meeting the Needs of the Community
*"The theme of the night was **Purpose Drives Passion**. The objective is to be the lighthouse of hope and healing for people seeking behavioral health services",* Claudia Vicencio, PhD, LCSW



Outpatient Behavioral Health Center Opening - VIDEO

https://m.youtube.com/watch?v=1Sa9QSVUUXQ

Thank You