Memorial Healthcare System

Board Community Relations Meeting
May 2024

Memorial Primary Care

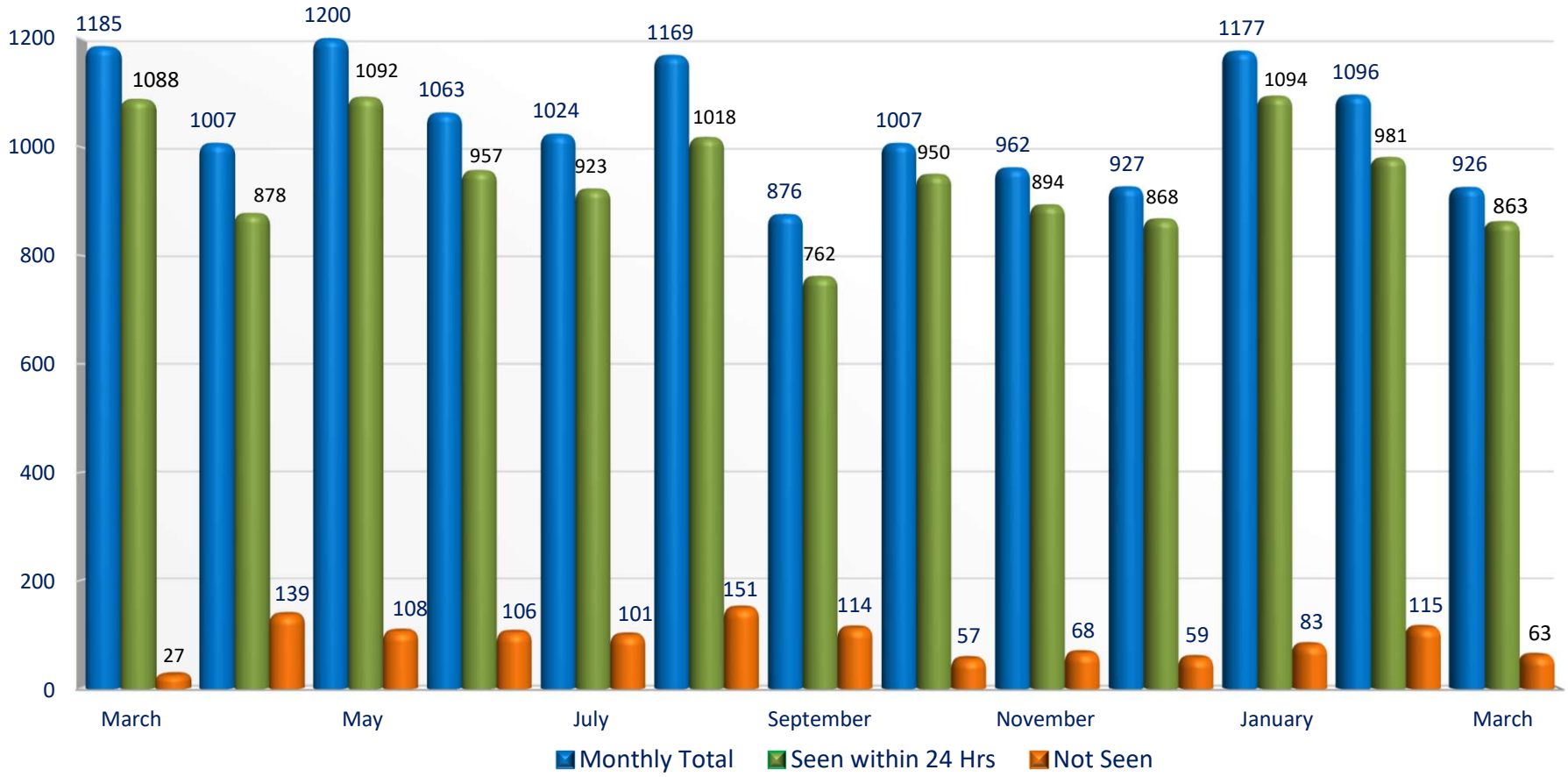
MPC Update

Quality Measures

Quality Measure Description	Rate	Peer Rate	Quality Rate
Breast Cancer Screening	80%	73%	Pass
Cervical Cancer Screening	71%	57%	Pass
Colon Cancer Screening	61%	54%	Pass
Comprehensive Diabetes Care: HbA1c Good-Control- Rate less than 8%	67%	61%	Pass
Controlling High Blood Pressure	68%	62%	Pass
Antidepressant Medication Management	72%	70%	Pass
Appropriate testing for Pharyngitis	51%	53%	Pass

Rates must be within 2 Standard Deviation of the average Peer

Same Day Access Statistics



MHS Sickle Cell Medical Home

- Volume
- Acute Pain
- Access
- Scheduling
- Services

Severe Maternal Mortality Telehealth Program

The program supports pregnant and postpartum women who are diagnosed with chronic care condition using Telehealth.
Program began October 2023.

- Referred to OB Navigator: 1,398
- Enrolled: 608
- Education: 546
- BP Cuffs distributed: 274
- Transmitted BP readings timely: 135
- Completed their postpartum visit: 286

Severe Maternal Mortality Telehealth Program

Key Performance Indicators FY 24-25:

- Reduce ED Visit for patients within 1 year related to pregnancy complications
- Reduce IP Readmissions for patients within 1 year related to pregnancy complications
- Reduce Maternal Mortality
- Reduce Infant Mortality

Black Maternal Health Baby Shower

Healthy Outreach and Pregnancy Education

- The program supports pregnant women from West Park who are at risk of poor birth outcomes and pregnancy related challenges.
- **Key components of program:**
  - Engage pregnant women at risk by community health workers through care coordination and home visitation.
  - Identify risk factors through Healthy Start screening, stress scale, and social determinants of health.
  - Identify challenges in the three areas of health: physical, behavioral, and social.
  - Connecting women (and their partners) to services to reduce risks in areas identified using wrap-around care coordination.

Project Hope| Population and Outcomes

- Served 78 pregnant women of African American, Haitian and Multiracial descent.
- Areas served included West Park, Pembroke Park, East Miramar, East Pembroke Pines, and south Hollywood
- 76 women delivered healthy babies with 2 babies being born with low birth weight that required NICU.
- 95% patients reported positive mental/emotional health.
- 97% of patients reported high satisfaction with program services.
- **Referrals and assistance provided to patients:**
  - Community Enhancement Food Pantry
  - Medicaid
  - Career Source Broward
  - WIC
  - Maternal depression
  - HITS eligibility
  - City of Hollywood Housing
  - FPL Assist
  - Family Success Center (utility assistance)

One City At A Time

One City At A Time Initiative

- Memorial has unveiled a population health initiative called “One City at a Time” that will station Memorial Primary Care Mobile Health Centers, or mobile units, within cities in South Broward for extended periods of time. Through this initiative we are bringing care, services, and resources directly to where some of our most vulnerable populations live.
- Through strategic partnerships with local communities, governments, and non-profit organizations we aim to create innovative and effective programs that tackle these community issues related to Social Determinants of Health, head-on.

The Opportunity

01

As our initial welcome to the city we would like to host a Kickoff at a local park or community center. The kickoff allows us to bring the mobile vans and other community partners to connect with the members of your city.

02

As the main part of our initiative we want to bring our Mobile Health Vans to the community for 3 days over the course of 8-12 weeks. We want to select strategic locations in the community to bring the healthcare to those of the greatest need in your community.

03

Over the course of 2 years, after our initial 8-12 week engagement, our mobile vans will stay in your city once a week. We will conclude the 2 years by conducting a closeout survey.

Community| One City At A Time

- **Mobile Health**
  - The One City at a Time initiative stations Primary Care Mobile Health Centers (mobile units) for 12 weeks in each of the 5 cities targeted in South Broward.
- **Medical professionals are on-site providing**
  - Vaccines, conducting health screenings, school physicals, referrals to dentists, nutritional counseling, and Social Determinants Of Health (SDOH) screenings.
- **HITS Program:**
  - Medicaid, Medicare and ACA eligibility determination. Linkage to community resources based on SDOH screening outcome: food pantries, legal aid, transportation, disability and employment resources.
- **Locations:**
  - Program has already taken place in 3 cities Hallandale Beach, Dania Beach and Hollywood, with plans to reach an additional two cities (Miramar & Pembroke Pines) in 2024.

Community| One City At A Time

- Total served in each of the OCAT cities Since May 2023
  (the first OCAT event in Hallandale Beach):
  - **Hallandale Beach:**
    - Adults – 151
    - Pediatrics – 328
  - **Dania Beach:**
    - Adults – 259
    - Pediatrics – 439
  - **Hollywood:**
    - Adults – 523
    - Pediatrics - 606
  - **Miramar:**
    - Adults – 290
    - Pediatrics – 311
  - **Pembroke Pines:**
    - Adults – 307
    - Pediatrics - 361

Community| One City At A Time

- **Common diagnosis in adults:**
  - Hypertension
  - Diabetes

- **SDOH referrals:**
  - 627 total linkages
  - Top 4 – Housing, Finances, Utilities, Food

- **Eligibility assistance:**
  - 278 individual applications
  - (Medicaid, Medicare, KidCare, ACA, MPC)

- **Upcoming OCAT Kickoff on June 29, 2024**
  - Location : Historic (East) Miramar
    Miramar Multi-purpose Complex

COMMUNITY HUB

The Community HUB

Helping to
Uplift and
Bounce back

Memorial Healthcare System

SDOH HUB Overview

Incoming Referral Overview

DRAFT

Data Source: Clarity Episodes and Referral Orders; Caboodle Patient and Flowsheet
Dates of Episode Creation: 8/15/2023 - 4/17/2024
Report Date: 4/18/2024 8:32:07 AM

Filters:

Domain	Referring Location	Year of Episode Start	Month Year of Episode Start
(All)	(All)	(All)	(All)

1. SDOH HUB Episodes

	2023					2024				Grand
	August	Septem..	October	Novem..	Decemb..	January	February	March	April	Total
Total	35	79	85	107	117	181	204	212	198	1,218

2. Incoming Referrals to the SDOH HUB by Referring Location

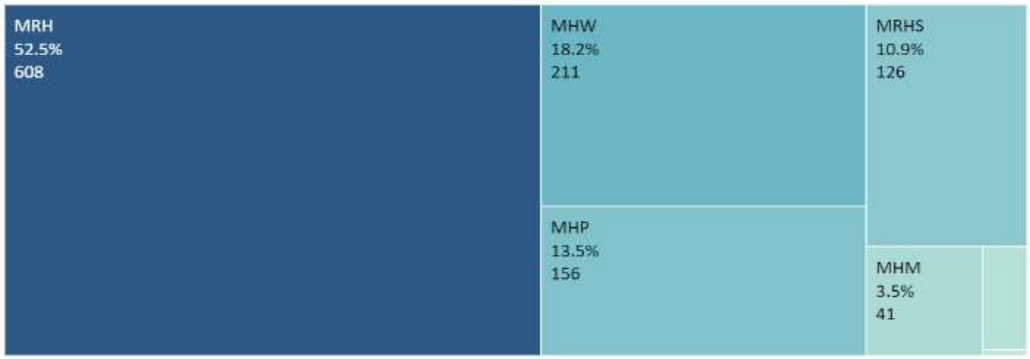
**More than 1 hospital may have made a referral.*

	2023					2024				Grand
	August	Septem..	October	Novem..	Decemb..	January	February	March	April	Total
Other	1	6	3	4	1	5	4	26	16	66
MHM	2	4	5	3	11	6	4	2	4	41
MHN			4	3	2	2	1	1	2	15
MHP	5	22	11	17	15	17	24	28	17	156
MHW	2	3	1	3	7	37	49	46	63	211
MPC WEST HOL..									1	1
MRH	22	38	51	61	61	94	102	96	83	608
MRHS	3	7	10	17	22	20	21	14	12	126
Grand Total	35	80	85	108	119	181	205	213	198	1,224

3. Incoming Referrals to the SDOH HUB by Domain

	2023					2024				Grand
	August	Septem..	October	Novem..	Decemb..	January	February	March	April	Total
Other	1	6	3	4	1	5	4	26	16	66
Financial Security	27	63	66	87	95	147	162	147	146	940
Food Insecurity	22	44	43	61	69	96	117	105	79	636
Housing	23	45	45	64	65	104	106	99	83	634
Transportation	20	35	32	39	31	50	67	64	47	385
Utilities	10	30	20	44	41	66	76	61	53	401
Grand Total	103	223	209	299	302	468	532	502	424	3,062

4. Incoming Referrals to the SDOH HUB by Referring Location



5. Incoming Referrals to the SDOH HUB by Domain

Filters selected: Domain: **All**; Referring Location: **All**; Year of Episode Start: **All**; Month Year of Episode Start: **All**

SDOH Impact| Patients with food insecurity

- Patients identified as food insecure at Memorial had reduced avoidable services in the 6 months after food insecurity was identified and addressed.

- ✓ 7.6% decrease in emergency room visits
- ✓ 13.9% decrease in admissions
- ✓ 5.3% decrease in readmissions

Improve Patient Outcomes

Food Insecure Patients:

- 63% of patients have Hypertension
- 56% have Hyperlipidemia
- 54% are obese
- 57% are Black
- 72% are women
- Most have >1 domain at risk

Based on documented Z-codes for food insecurity and the comparison of services completed 6 months pre-screen to 6 months post-screen.

MEMORIAL HEALTHCARE SYSTEM

Memorial Healthcare System

SDOH HUB Overview

Outgoing Referrals Detail

DRAFT

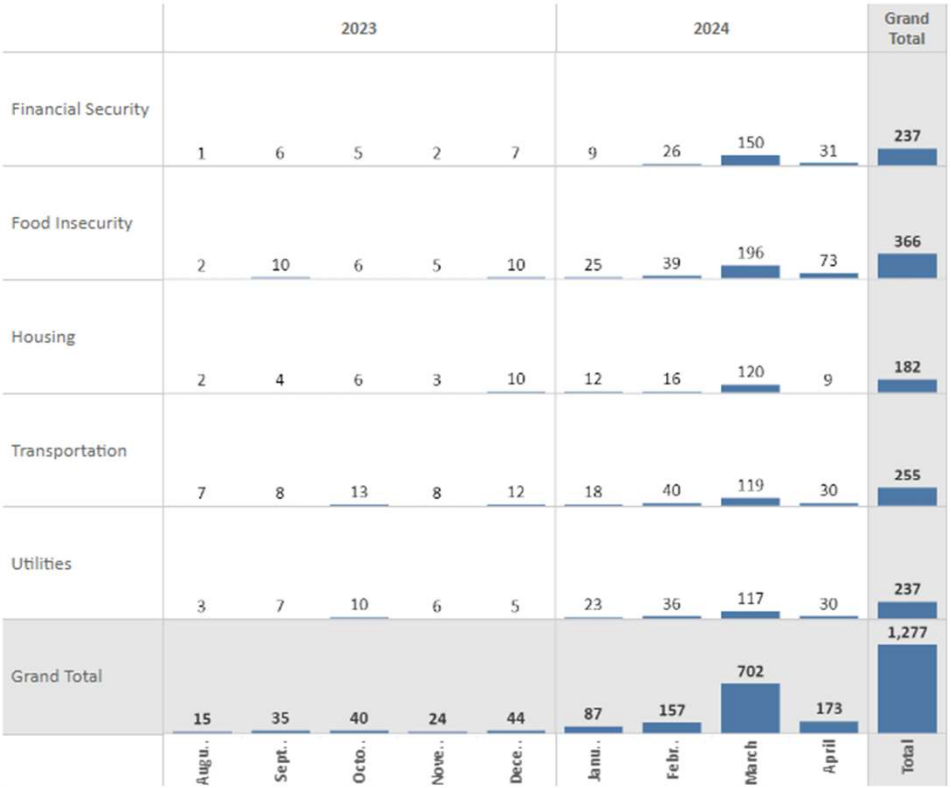
Data Source: Clarity Episodes and Referral Orders; Caboodle Patient and Flowsheet
Dates of Episode Creation: 8/15/2023 - 4/17/2024
Report Date: 4/18/2024 8:32:07 AM

Filters:

Domain	Referring Location	Year of Episode Start	Month Year of Episode Start:
(All)	(All)	(All)	(All)

1. SDOH HUB Outgoing Referrals by Domain

Outgoing Referrals made by the HUB to community programs, summarized by Domain.



2. SDOH HUB Outgoing Referrals

Outgoing Referrals made by the HUB to community programs, sorted descending by Resource.

Resource	2023 August	2023 Septem..	2023 October	2023 Novem..	2023 Decem..	2024 January	2024 February	2024 March	2024 April	Grand Total
LIHEAP (FPL bill)	2	5	7	5	5	23	36	110	18	211
Feeding South Florida	1	7	3	3	10	5	7	110	52	198
TOPS	6	6	10	6	11	8	28	98	24	197
Family Success Center (Broward)	2	4	6	2	10	7	12	100	4	147
Center For Working Families (Hispanic Uni..	1	2	5		1	3	4	99	27	142
WECARE food pantry		1		1		18	27	68	13	128
Career Source		3		2	6	6	22	33	4	76
Community Shuttle (some cities have their..	1	1	2	2	1	8	10	7		32
Broward county paratransit (bus passes)		1	1			2	1	13	5	23
Broward Housing Authority		2	1	1		1	1	14	2	22
Goodman Jewish Family Services of Browa..			2	1		1	3	8	3	18
CEC	1	2	1	1		1	1	6	4	17
Hispanic Unity of Florida (Food Stamps ap..			2			1		10	4	17
Family Success Center (water and FPL)	1							2	11	14
Urban League of Broward		1						11		12
Consolidate Credit								7		7
HOPE outreach center							4	2		6
Catholic Housing Management (Miami an..						3				3
Logistic Care (Transportation) Medicaid							1	1	1	3
Home emergency assistance for elderly EH..								2		2
HOPE outreach center (Davie residents)								1	1	2
Grand Total	**15**	**35**	**40**	**24**	**44**	**87**	**157**	**702**	**173**	**1,277**

Filters selected: Domain: **All**; Referring Location: **All**; Year of Episode Start: **All**; Month Year of Episode Start: **All**

Patient's Story| The HUB Impact

Social challenges: food insecurity, housing, utilities and financial resources strain

- **Patient:** is a 79-year-old male that presented to the emergency room due to right lower swelling due to a scratch patient sustain about 2 months ago. Patient was later diagnosed with necrotizing fasciitis required surgery for debridement and partial firth toe amputation. Patient lives with his 80-year-old spouse. Patient and spouse do not have any immediate support and their sons live far away. Patient was unable to be discharge from hospital as patient did not have a working refrigerator, and patient would need IV antibiotic for the next month, which must be store in a refrigerator and did not have anyone that could aid in obtaining it.
  - **Onsite assessment was completed and identified areas of need including:**
    - Lack of working refrigerator to store medication.
    - Food insecurity
    - Financial Strain
    - Utilities
    - Socialization
- **Interventions Provided:**
  - Purchase of a compact refrigerator
  - Referral for HITS for food stamps, Medicaid and Medicare savings plans. Food pantry list for Broward was also provided and food delivery was done
  - Utility resource : Goodman Jewish Family Services, Family Success for LIHEAP and LIHWAP programs, Salvation Army- FPL Care to Share and Area Agency of Ageing of Broward County.
  - Referral to ALLIES program.
- **Outcomes:**
  - By providing and installing the refrigerator, patient's discharge process could be continued so that he might return home and assist his wife.
  - Patient and his wife were immediately connected with the ALLIES program for case management and socialization.
  - HITS program completed food stamps, Medicaid and Medicare application, pending approval

MHS SDOH Final New Logo
vimeo.com

Memorial Healthcare System

Questions?