Florida Health Networks (FHN), an associated organization of Health Foundation of South Florida (HFSF), partners with Aging and Disability provider networks and other community-based organizations. FHN supports contracting with managed care plans and allows direct service delivery of billable Preventive Health and Wellness services to Medicare fee-for-service beneficiaries. The following overview details the flow of services from referral to service delivery and documentation back to referring provider.

Aging and Disability Resource Centers, and a diverse network of service providers, will deliver a menu of evidence-based programs that lead to improved health promotion and comprehensive care coordination services to assist older adults and people with disability in reaching optimal health outcomes to achieve the Triple Aim.

**Goals:**
1. Improved linkage with the Patient Centered Medical Home
2. Improved adherence with Specialty referrals
3. 15% reduction in ambulatory sensitive emergency room visits
4. 15% reduction in ambulatory sensitive admissions
5. 25% reduction in all cause readmissions
6. 15% reduction in overall medication costs
**What we do**

Florida Health Networks provides a multi-disciplinary care team that supports the provision of direct medical care, in a patient-centered manner. Our person-centered approach works with the Accountable Care Organization (ACO) or Managed Care Organization (MCO) to extend health promotion and disease prevention into the community. All wellness and preventive services are part of the MLR. The multi-disciplinary care team includes the following clinical team members that support the patient-centered medical home:

- Nurse Practitioner
- Registered Nurse
- Registered Dietitian
- Licensed Clinical Social Worker
- Psychologist
- Physical Therapist
- Trained Community Health Worker

**Population Health Software**

- Proven technology solution supporting multiple ACOs and MCOs
- Integrated with GE Healthcare analytical tools
- Johns Hopkins ACG Risk modeling analytics
- Cloud based – supports health workers using web-enabled tablets
- Secure, Certified HIPAA compliant care management application. No data stored locally on tablet devices
- Supports HIE Direct, HL7, CCD
- Analytics track utilization, costs, and risk-based on claims analysis, clinical outcomes, and utilization history

**How we are different**

- Complement and integrate with existing programs, specifically Health Plan and ACO care management
- Provide easily accessible and culturally competent ‘neighborhood-based’ programs delivered by trusted age-friendly providers working under the supervision of clinical staff
- Community Health Workers (CHW), trained in multiple evidence-based programs and in all CHW competencies, provide education and support to patients where they live
- All wellness and preventive services are part of the MLR
Appendix N
Menu of Community Services

Referral for Preventive Health & Wellness Eval → Community or Transitional Care Referral → Hospital → Complete transitional care management plan and provide 30-day follow-up (TCM-$)

Population stratified by risks and enrolled in CCM-$/WIM-$ → Complete preventive health risk assessment and develop Wellness plan (AWV-$)

Referral for Preventive Health & Wellness Eval → Complete preventive health risk assessment and develop Wellness plan (AWV-$)

Diabetes: Enroll and Participate in a DSMT Course (DSMT-$) → Continue CCM to link consumer to other preventive health services – based on risk → Complete intervention and submit clinical documentation to referring provider

Fall Risks: Enroll in a Fall-risk prevention program (Otago/MOR-$) → Continue CCM to link consumer to other preventive health services – based on risk → Complete intervention and submit clinical documentation to referring provider

Depression: Enroll in a depression intervention (Indiv/Grp-$) → Continue CCM to link consumer to other preventive health services – based on risk → Complete intervention and submit clinical documentation to referring provider

Chronic Diseases: Enroll in a Chronic Disease Self-Management Course (HBAI-$) → Continue CCM to link consumer to other preventive health services – based on risk → Complete intervention and submit clinical documentation to referring provider

Florida Health Networks
About Health Foundation of South Florida

Health Foundation of South Florida, a nonprofit grant making organization, is dedicated to improving health in Florida with a special focus on Broward, Miami-Dade and Monroe Counties. By funding providers and supporting programs to promote health and prevent disease, the Foundation makes a measurable and sustainable impact in the health of individuals and families. Since 1993, the Foundation has awarded more than $106 million in grants and program support.

The Foundation’s innovative initiatives which focused on older adult populations, the Healthy Aging Regional Collaborative and Age-Friendly Miami-Dade, have been nationally recognized. In just five years, the Collaborative served over 36,000 older adults with evidence-based programs and increased physical activity by 75% in clients served during that time. Based on its success with effective programming for older adults, Health Foundation recently launched Florida Health Networks, in partnership with Florida Area Agencies on Aging and other community based organizations, to provide health services to older adults and dual eligible adults in Florida working with health plans and government agencies.

For more information, please call 305.374.7200 or visit www.hfsf.org.

Glossary:

AWV: Annual Wellness Visit
CCM: Chronic Care Management
DSMT: Diabetes Self-Management Training
HBAI: Health Behavior Assessment and Intervention
IBT: Intensive Behavioral Therapy
(Medical Loss Ratio
MOB: Matter of Balance
MTM: Medication Therapy Management
TCM: Transitional Care Management