

# Citizen’s HealthCare Oversight Committee Meeting

January 15, 2016	8:30 – 10:30 a.m.	Neil Combee Administration Building - Boardroom
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Chairman	Dr. Thomas E. McMicken
Attendees	T. Aman, L. Anastasio, K. Andrews, A. Haywood, Dr. McMicken, D. Moses, W. Murrell, P. Rust, H. Vida, Dr. Jackson, J. Johnson, L. Thomas, J. Marchi, Dr. Wills, and S. Craver

## Initial Business

Approval of Minutes	<ul style="list-style-type: none"> <li>▪ Motion to Approve: D. Moses</li> <li>▪ Second: L. Anastasio</li> <li>▪ Minutes unanimously approved.</li> </ul>
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Vote for Chair & Co-Chair	<ul style="list-style-type: none"> <li>▪ Vote for Chairman: L. Anastasio nominated Dr. McMicken to remain Chairman.</li> <li>▪ Second: K. Andrews</li> <li>▪ Dr. McMicken: Motion approved.</li> <li>▪ Vote for Co-Chairman: W. Murrell nominated L. Anastasio</li> <li>▪ Second: D. Moses</li> <li>▪ Dr. McMicken: Motion approved.</li> </ul>
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## Announcements

Updates	<ul style="list-style-type: none"> <li>▪ No public comments.</li> </ul>
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## Presentations

Update	Joy Johnson, IHC Director
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Discussion	<ul style="list-style-type: none"> <li>▪ J. Johnson demonstrated how to access health service information using the Polk County Website (<a href="http://www.polk-county.net/bocccsite/Departments/Health-Services">www.polk-county.net/bocccsite/Departments/Health-Services</a>) and provided an infographic featuring informational highlights from the website. The infographic will be updated over the next upcoming months and will be used to educate the community and public about the Indigent Health Care (IHC) program.</li> </ul>
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2015 IHC Annual Report	Joy Johnson, IHC Director
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Discussion	<ul style="list-style-type: none"> <li>▪ Presentation given by Joy Johnson.</li> <li>▪ L. Anastasio – How will the Low Income Pool (LIP) money change this year compared to last year?</li> <li>▪ J. Johnson – There’s no new matching opportunities, the IHC fund is paying for all services being provided and there’s no match funds being funneled out for new programs. For example, the Primary Care LIP Grant, instead of the County paying the \$1.6 M we would end up paying the full amount of \$3.3M that we presented last month. All of that will come out of the IHC fund instead of a portion of it. It’s the same with the hospitals, we are processing those claims and some of those hospitals may have a balance hanging out there, which we do track on an ongoing basis, and we’ll make sure that those funds are exhausted before we send payment for the claims.</li> <li>▪ W. Murrell – I want to point out, the projected fund balance is one scenario and we’re looking for an extension of the ½ cent sales tax. Our first opportunity for the approval is this coming November and we have a couple of opportunities after that. Certainly, the projected fund balance will change based on the results of how that goes. We’re not necessarily looking at a total sun setting of the fund.</li> <li>▪ J. Johnson – As you saw in the 5 year projections with the LIP grant no longer allowing those matching opportunities for us, in order to maintain those service levels, the current service levels and the expanded programs that we’ve done over the last year or two, the payment is coming completely out of the IHC program. That’s what is helping to gradually decrease those reserves going into the next 5 years.</li> <li>▪ Dr. McMicken – When you look at this on the surface, it all looks fantastic and I agree that it is. The County has done an excellent job with this program; however, I think one thing that the public would like to know, when we look at services rendered and the cost, is what the cost per service is? That’s the only thing that’s missing. There are all different types of services like primary care, specialty care and those types that we produce. In any future presentations that might be made to the public concerning the ½ cent sales tax, try to come up with something the public can understand. What is the cost per service and make sure we are efficient in our delivery.</li> </ul>
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# MINUTES

<p>2015 IHC Annual Report (cont.)</p>	<ul style="list-style-type: none"> <li>▪ J. Johnson – I would be glad to take a look at that. It varies across our community partners and our providers so it’s not the same across the board, but we do have some information that I’d be glad to put together and show you.</li> <li>▪ Dr. McMicken – I understand that in order to get a clear picture we would have to know what their total budget is and I’m not sure that we’re entitled to all the information.</li> <li>▪ J. Johnson – That’s the challenge we have in trying to present because we don’t have all of their program information reported to us and we don’t currently ask for that. Based on the information that is provided to us, we can put some information together.</li> <li>▪ Dr. McMicken – I think that would be interesting to the public whose inquiring; what is the cost per service and is it efficient use of our tax dollars.</li> <li>▪ J. Johnson – Also I’d like to add that as we work with the University of Florida on our economic impact analysis that’s some of the information that we want to get feedback on from them based on the data that’s available while we look it up ourselves. We’re hoping that come April or May we’ll have some good feedback and a full scale broader study on some of that information.</li> </ul>
<p>IHC Financial</p>	<ul style="list-style-type: none"> <li>▪ Kelvin Almestica, IHC Fiscal Analyst</li> </ul>
<p>Discussion</p>	<ul style="list-style-type: none"> <li>▪ Presentation given by Kelvin Almestica.</li> <li>▪ L. Anastasio – We’ve had such extraordinary recoveries, with Medicaid expansion would you expect you’re going to continue to see favorable recoveries? It’s the one account for \$38K that’s pushing us over budget, but with the expansion of Medicaid are we likely to see greater recoveries than budgeted? Similarly, are we likely to see the pharmacy recovery and rebates increase as we look forward? Those are both extraordinary numbers.</li> <li>▪ K. Almestica – In the past, we’ve not seen a lot of recoveries because most of the Polk HealthCare Plan (PHP) hospital claims were paid through the hospital LIP buyback, so that was not hitting our books. Part of the regulation, we’re not allowed to recover that money directly from the hospital. Now that we’re directly cutting a check for those hospitals we can recoup the money, if there’s any. Usually, what happens is the patient will become eligible for Medicaid or there are payments that were denied in our payments. Yes, I anticipate this year we’re going to go almost 200% of what we anticipated on the budget.</li> </ul>
<p>IHC Medical Director Update</p>	<ul style="list-style-type: none"> <li>▪ Dr. Todd Wills, IHC Medical Director</li> </ul>
<p>Discussion</p>	<ul style="list-style-type: none"> <li>▪ Presentation given by Dr. Todd Wills.</li> <li>▪ Dr. McMicken – I suggest we dissolve these committees and if something comes up that needs to be discussed in a smaller group, then we could have a small committee of the physician member panel to include the medical director, the director of the plan, the pharmacist and any other party that would have a significant interest in the planning. I know there’s been some discussion about expanding behavioral health and whether that needs anymore planning, what staff can do or any input from anybody else can be left up to the medical director or the director of the plan to pull together anybody that you think you need to have a preliminary meeting.</li> <li>▪ Dr. Wills – Even some of these functions that may have existed in the past, if we come to a point where we need to significantly address benefits or the formulary we can regenerate an add hot committee or a short term committee that does those same things. The requirement to have it and the replication of a committee that is there largely for people to attend but not to do anything has become less useful for everyone involved.</li> <li>▪ T. Aman – In your presentation and in Joy’s your hospital admissions number was 571 and when you compare that to the total number of patients that are covered by the plan that seems high. I’m assuming that’s total admissions and not unique patients admitted, is that correct?</li> <li>▪ Dr. Wills – Yes, that’s total admissions and some of those are recurrent. I think probably 100 of those at least are repeat individuals.</li> <li>▪ T. Aman - Is that something we should start looking at? In the private sector preventing readmissions within a certain timeframe is a real focus both for outpatient clinics and primary care, as well as hospitals. Are there any plans to look at readmissions and preventing that? Because again that is going to help drive our cost down.</li> <li>▪ Dr. Wills – There’s two approaches we’re taking to that and they’re in very early development. The first one, we’ve discussed in a couple of meetings, which is to try to adjust our high cost clients. To identify those that incur a lot of plan related costs and beginning a case management program to target them specifically. Among those will be people whose higher costs are related to frequent hospital admissions and we’re going to try to identify holes in their or barriers to their proper care that we might be able to fix and reduce those risks for readmission. One of the operational things</li> </ul>

# MINUTES

	<ul style="list-style-type: none"> <li>▪ Dr. Wills (cont.) – that limit our activity in responding directly to readmission for high risk patients is most of our hospital claims, up till now, have been analyzed retrospectively. Unlike other private entities where a patient is hospitalized and the plan is notified and they have real time analysis of the hospital stay, the eligibility for that hospital stay, the length of stay and then the knowledge of when discharge occurs, we find out by claims of the hospitalization after it has occurred. We don't have that real time ability to say PHP member has been discharged. How can we link up to them to prevent readmission? We have begun to get remote real time access with some of our hospital partners so that we will be able to at least query their census for members of our plan. Then with that we can implement some identification of discharges and seeing if there are things we can implement to link those patients to proper outpatient care and prevent readmission.</li> <li>▪ Dr. McMicken – I suggest the first diagnosis you look at is congestive heart failure. There is a lot being done now to prevent repeat admission for congestive heart failure.</li> <li>▪ Dr. Wills – What will allow a lot of entities to work together on that is the hospitals are penalized for readmission and they don't want patients to be readmitted. We don't want them to be readmitted and have to pay for an extra hospitalization either and for the wellbeing of the patient you want that link to occur. Everyone has financial as well as patient welfare motivations to say how can we take this patient that has been acutely stabilized and get them the care they need so that's a very episodic event.</li> <li>▪ Dr. McMicken – A lot of those conditions, especially congestive heart failure, they should make sure they have a follow up visit within a week after they've left the hospital, preferably within 3 days.</li> <li>▪ Dr. Wills – Again, some of our high cost case management will address some of those issues for patients that have a diagnosis of heart failure, COPD or asthma where a patient education, a follow up plan, weighing themselves or measuring their peak flows, etc. can be part of their ongoing outpatient management. That's what our medical management nurses will do with them.</li> </ul>
FDOH Update	<ul style="list-style-type: none"> <li>▪ Dr. Joy Jackson, Florida Department of Health Director</li> </ul>
Discussion	<ul style="list-style-type: none"> <li>▪ Dr. Jackson gave a public health update regarding the influenza activity in Polk County, reporting that it is mild so far this year and that there are some areas in the country that are starting to see some flu, and it is predominately influenza A which is being monitored closely. Fortunately, the vaccine strains are comparable to what strains are starting to occur across the nation. Flu vaccines are still recommended and it takes about 2 weeks for them to be effective but again the CDC recommends vaccination for most Americans ages 6 months and older.</li> <li>▪ January is birth defects prevention month. Encourage all young women who are anticipating becoming pregnant to plan ahead, avoid harmful substances, choose a healthy lifestyle, and connect with a physician. Also, this week is National Folic Acid Awareness Week. Again, encouraging young women who are anticipating pregnancy to be on folic acid supplementation to reduce the risk of birth defects.</li> <li>▪ Literacy is an issue this month, the last week of January 25<sup>th</sup> through 29<sup>th</sup> is Celebrate Literacy Week. This is an annual event and this is a time when students, teachers and administrators, parents and volunteers celebrate the success of students and promote literacy in our communities. The Department of Health is marking this event by reading to a group of students at Gibbon Street Elementary School on January 28<sup>th</sup>. Enjoy the opportunity to partner with our school system. Studies show a link between literacy, long term health outcomes and quality of life.</li> </ul>
Final Comments	
	<ul style="list-style-type: none"> <li>▪ No final comments.</li> </ul>
	<ul style="list-style-type: none"> <li>▪ Motion to adjourn meeting: P. Rust</li> <li>▪ Second: H. Vida</li> <li>▪ Meeting adjourned.</li> </ul>
Transcribed by	<ul style="list-style-type: none"> <li>▪ Indigent Health Care Division – Stacy Craver</li> </ul>
Special Notes	Next COC Meeting: February 19, 2016