

Citizen’s HealthCare Oversight Committee Meeting

June 17, 2016	8:30 – 10:30 a.m.	Neil Combee Administration Building - Boardroom
Chairman	Dr. Thomas E. McMicken	
Attendees	T. Aman, L. Anastacio, K. Andrews, D. Moses, W. Murrell, T. Saunders, H. Vida, Dr. Young, D. Zimmerman, Dr. Jackson, J. Johnson, L. Thomas, J. Marchi, Dr. Wills, S. Craver	
Initial Business		
Approval of Minutes: May 20, 2016	<ul style="list-style-type: none"> ▪ Motion to Approve: D. Moses ▪ Second: L. Anastacio ▪ Minutes unanimously approved. 	
Announcements		
Updates	<ul style="list-style-type: none"> ▪ No public comments. 	
Presentations		
Medical Director Update	Dr. Todd Wills, IHC Medical Director	
Discussion	<ul style="list-style-type: none"> ▪ Presentation given by Dr. Todd Wills. ▪ Dr. McMicken –The 276 patients that you have under case management are people with hemoglobin A1C’s over 9, is that right? ▪ Dr. Wills – Yes. ▪ Dr. McMicken – That doesn’t represent the average hemoglobin A1C among the diabetic population that you see? ▪ Dr. Wills – Right. ▪ Dr. McMicken – It would be interesting to know how many diabetics are really controlled with hemoglobin A1C of 7 or less. ▪ Dr. Wills – I can work on getting that from our LabCorp database; we can query our database and look at all of our patients and see where they lie. ▪ Dr. McMicken – If you look at the manufacture’s price on what insulin costs at the drug store, there isn’t a lot of difference between the pen and the vial. Pen needles are much more easy to use and easier for people to be able to see. The newer long acting insulins, as far as I’m concerned, have less hypoglycemic reactions than Levemir does and Levemir is a twice a day dose. The others don’t seem to be more expensive than Levemir, unless there’s some sort of a contract problem. I wonder how often the formulary committee meets because those would be a lot better drugs on the formulary. ▪ Dr. Wills – In our formulary meetings, what we typically have done is, we work with Welldyne or benefits manager to look at overall costs of an injectable insulin package and by having one exclusive provider versus another we’ve had some eligibility for rebates. It is true that the pens are a more desirable delivery device and we’re going to explore if we can do those through patience assistance. We may find that even if that doesn’t work, making that our formulary alternative might be a reasonable choice. ▪ Dr. McMicken – I assume with what you’re talking about would increase the, looking at some of the other diabetic medicines, injectable JOB 1 inhibitors? ▪ Dr. Wills – Yes. Again, part of this is exploring the process and exploring what the manufacture’s pushback is about eligibility status as well, but we should be able to realize a lot more options for those patients. ▪ Dr. McMicken – If you look at the evidence based medicine out for the selection of diabetic products, I think in our formulary we should at least have what’s recommended as far as the steps to go from one to the other. ▪ Dr. Wills – Yes. 	
Lakeland Volunteers in Medicine	Robert Yates, President/CEO	
Discussion	<ul style="list-style-type: none"> ▪ Presentation given by Robert Yates. ▪ D. Zimmerman –You said October 2015, so this is 9 months of data? ▪ R. Yates – Yes, the medical contract. The dental contract was the 1st of this calendar year so far. ▪ D. Zimmerman – When did your dentist leave? ▪ R. Yates – Last Friday. 	

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<p>LIVIM Discussion (cont.)</p>	<ul style="list-style-type: none"> ▪ W. Murrell – You mentioned access to care; at the Winter Haven emergency department we had a lot of presentations there and a lot of people presenting uninsured with dental issues. At that time, going to Lakeland for care was a far distance to travel to have it taken care of. I totally agree with you and would say that based on the improvements that had been noted at Winter Haven for a reduction of dental visits, primarily because of a clinic opening within a mile of the emergency room, access is something we need to continue to address. ▪ R. Yates – Yes, that’s a good point. We work with the emergency room at Lakeland Regional where if they have a patient presenting with dental problems they do pain relief, maybe start an antibiotic and then they refer to Lakeland Volunteers in Medicine dental program. Then we’re able to take care of that situation, that’s what really helps the patient long term and decreases the expense of medical care for all of us. ▪ Dr. Young – The length, 5 day service, on dental or part time as what you’ve been having in the past and what do you want to bring that up to? ▪ R. Yates – The most recent grant award allowed us to bring that up to fulltime. The dentist that was on staff actually worked 10 hour days, Monday through Thursday. The clinic is open for volunteer dentists on Friday and Saturday. It’s a pretty robust program and we’re very fortunate that we have the ability to do this and we will fill that position with a fulltime dentist.
<p>WH Hospital Center for Behavioral Health</p>	<p>Teresa Even, Manager of Behavioral Health Services</p>
<p>Discussion</p>	<ul style="list-style-type: none"> ▪ Presentation given by Teresa Even. ▪ W. Murrell – You mentioned that you’ve provided services to 13 clients, I realize that it’s a start up program and just getting underway and different patients offer different challenges. If you can take an average, what do you feel that your capacity would be at present overhead and staffing? ▪ T. Even – With the 2 individuals at this point, if they’re requiring fairly intensive which is a minimum of once a week, 25 to 30 clients would easily be accommodated. With a third person we could probably go to 40 or more. Also, the size of Polk County is going to impact it as well. ▪ T. Saunders –It’s early, but what do you anticipate the average length time in the program to be? ▪ T. Even – I’m not sure at this point. I would say typically if there are individuals who are working toward their goals, we are going to continue to help them do that and try to feed them into the outpatient setting. I’m thinking 3 to 4 months maybe up to 6, but we also want to use our time and energy as best as possible on those that are working toward their goals and trying to seek help. It’s so early, it’s hard to know. We’ve only lost 1 person because she moved to Texas. ▪ T. Saunders – On your timeline, it looks like you’re making that initial screening appointment very quickly. How long is it between the initial screening point and the second visit? ▪ T. Even – The second visit is within a week, as long as the client is able to accommodate that. ▪ T. Saunders – Are you including trauma history in that screening process? ▪ T. Even – Yes, it is a full biopsychosocial assessment including trauma, doing the PHQ9 for depression and a crisis plan, if needed. ▪ Dr. McMicken – Do you have the availability to a psychiatric nurse practitioner or psychiatrist? ▪ T. Even – Yes, we do. They do not go to the home but they are in the office at the Center for Behavioral Health for appointments, typically within 1 to 2 weeks.
<p>Central Florida Health Care</p>	<p>Ann Claussen, CEO</p>
<p>Discussion</p>	<ul style="list-style-type: none"> ▪ Presentation given by Ann Claussen. ▪ D. Zimmerman – Do you know how many people on the high volume of services that would be duplicates on hypertension, obesity or diabetes? ▪ A. Claussen –On those categories we would probably see the diabetics, if we can get them in, at least 3 to 4 times a year and the same with hypertension because those patients are generally on medication and we want them to come back and have follow up visits to monitor the diabetes as well as hypertension. ▪ D. Zimmerman – How many are counted in each of the categories multiple times? ▪ A. Claussen –If a person has both hypertension and diabetes, I’m not sure of the exact number. I think the answer is yes, we usually see the chronic patient will have a variety of conditions. ▪ Dr. McMicken – With all these sources of funding we see what the return on investment is but I what I see is about 100,000 visits for \$17M, is that correct? ▪ A. Claussen – Overall? ▪ Dr. McMicken – That would be about \$170 per visit? A. Claussen – I think that’s roughly. ▪ Dr. McMicken – What I would really like to see is what the efficiency is; I’d like to know how many patients per day do the providers see?

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CFHC
Discussion (cont.)

- A. Claussen – I know that question gets asked, we have about 45 providers, a lot of different specialties, and they are spread out in Polk, Highlands and Hardee counties. What happens with CFHC and the guidance that has been through the federal government through HRSA is they want us to focus on quality, not quantity.
- Dr. McMicken – You can still have quality with quantity.
- A. Claussen – Oh yes, absolutely. It varies from type of provider because a lot of patients we get that come in are the very chronically ill.
- Dr. McMicken – Let's talk about primary care.
- A. Claussen – Primary care on average, the doctors can see anywhere from 18 to 22 patients a day and our ARNPs see anywhere from 14 to 16 a day. That depends on the type of care that comes in. If it's that diabetic patient or the patient with the chronic illnesses, it does tend to move their numbers down a little. Most of our doctors, if they have patients that are coming through and they're not really complicated cases, can easily see over 20 patients a day.
- Dr. McMicken – That's about average. Do you have access to patient education for your diabetic patients?
- A. Claussen – Absolutely.
- Dr. McMicken – Is the majority of that group, one on one or do you know?
- A. Claussen – It depends, we have our director of pharmacy who does group classes for the diabetics and we also offer individual consultation to all of our patients. The new teaching kitchen will allow us to do group.
- Dr. McMicken – I'd like to see your data, if possible. The focus is on hemoglobin A1C and I'd like to see data of your diabetic patients and their levels. You know 9 is a level you want everybody to be below but that's not anywhere close to optimum, as your medical director I'm sure knows. A lot of that depends upon your access to medications that works better than what most people's formularies are. It would be interesting to see what your average hemoglobin A1Cs are among your diabetics as far as quality goes. If we're going to talk about quality, it's important to have the data and see if you've got the quality.
- A. Claussen – Right and we do; I apologize that I don't have those specifics for diabetes today but we do have data for that.
- Dr. McMicken – Hypertension, too. In private practice, of course, most electronic medical records (EMRs) are designed to be able to collect data so you can prove meaningful use and quality and they're a whole bunch of different criteria that you have to collect the data for. Two of the major ones that people are looking at are hypertension and diabetic control and complications. I'd like to see presentations that don't just show the numbers but shows the quality. An initial diabetic evaluation with getting the lab and doing a little patient education yourself is probably going to take 45 minutes to an hour. If you can get their hemoglobin A1Cs under decent control, follow up visits you can see most of those people in 15 minutes.
- A. Claussen – That's true, follow up visits are very quick. The issues we run into are a lot of our patients don't come back until they are in need of the medication or it's more chronic nature.
- Dr. McMicken – That's where the patient education comes in. People are notoriously non-compliant. Everybody pushes for quality care but sometimes the biggest problem with quality care is the patient and I'm not sure I know exactly how to solve that problem. We appreciate you and think you've done a great job. That's some of the questions I have and would like to see presented in the future.
- A. Claussen – I'd be happy to.
- T. Aman – I echo some of the concerns Dr. McMicken has, you guys do wonderful work in the community. As you present, I continue to question the numbers that you're seeing. While your providers in primary care are seeing an average of 20, that is average but it's really on the low end of average when you look at primary care physicians. What's your criterion to push that mark a little bit? In reference to the quality, when I first saw your slide of the quality reportable outcomes, these are great and it looks like you've definitely shown improvement, but it would be nice to see what your benchmarks are and what you're measuring that against. Adult BMI you've shown 83.9% improvement, are 83.9% of the patients now within a normal BMI or are there just improvement of some type. The same way with hypertension and diabetes, is there improvement or are we improving to a more normal level? Those would be really good things to show what your quality measures are as far as your benchmarks and what your guiding that as.
- A. Claussen – We keep all of those measures, we're required to. Because we're a federal qualified health center and we receive federal funding. They are looking at our quality measures at all times. I hear what you're saying as far as the average number of patients but I think in our world it's a little different because we are a federal qualified health center. We're falling in line with

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- A. Claussen (cont.) – the guidelines that Health Resources and Services Administration (HRSA) presents to us for the average number of patients per day so I want to say that to clarify that HRSA is looking to us to see those patients each day and in their eyes we are meeting the needs. It's very difficult to compare us to private practice; private practice is different, you can get the patients in and out quicker and sometimes they're not as chronically ill. That's what drives our numbers down a little is the chronic nature of our patients. Remember, we're seeing patients that have transportation issues, their on Medicaid or uninsured and so by the time we see them they're in chronic conditions and it takes longer but our goal is always to see more patients per day.
- T. Aman – For your fulltime providers, what is their available appointment time per week and how many hours per week of available appointment time do they have with primary care?
- Dr. Ham-Ying – I'm Dr. Michael Ham-Ying, the chief clinical officer for CFHC. On a typical 8 hour day, we leave about an hour to an hour and a half to administration and the rest of time is divided up between medical appointments, opportunities for same day appointments and walk ins, that's how we generally have it structured. As for our average number of patients per day, your average practice because I've had some time in private practice, we don't have average patients. We have patients that have special needs, several chronic care needs that have not had access to care, extremely non-compliant and transportation issues. Trying to arrange for services for them and trying to find medicines that they can afford, even though we do have a 340B pharmacy to assist with that, all those things are challenges that make a patient appointment much more difficult. Our doctors are far more involved with the patients in terms of trying to meet their needs than your average physician would be in private practice. If we can see what the average doctor in private practice sees, then that's phenomenal. That's not saying that we're average like everybody else, for my perspective, it's phenomenal.
- Dr. Young – I would agree with you, and I applaud you for expanding into the specialties areas Anytime a person is in a specialty area it usually takes more time. I think you're doing a fine job; I'm very pleased with your programs.
- Dr. Ham-Ying – We're doing the best that we can and what we've outlined today, one of the things that have been brought to our attention is the high need for dental care. We provide both medical and dental care. We try to shift our focus according to what's presented to us as the biggest needs in the community. Dental care is extremely expensive; in fact, adult care has very little reimbursement. It's always a challenge trying to have a sustainable program for adult dental care. We've done our best in terms of trying to use other programs that we have such as our pharmacy to try to generate revenue to support our dental program. Pediatric dentistry is different because there is reimbursement for pediatric dentistry. We've been doing our best to try to meet those needs and the request to try to add dental services in Mulberry; it's been presented to us as an area that has a very high need for dental services. We've been extremely fortunate to find an excellent bi-lingual dentist to bring into that area. We stuck our necks out and extended an offer for that dentist but now we have to find a way to pay for the dental equipment to support that person by September.
- Dr. McMicken – Have you ever done a study or tried to find out exactly how big an issue the transportation problem is for these people to try to see if there's something we can do to solve that problem, if the problem exists? That would be an important thing to look at. Maybe you can monitor the patients that do come in to see if they have transportation problems, difficulties getting to the clinic or difficulties getting access. Then we can study a solution to try to solve it.
- A. Claussen – We do and have done a lot of studies and our navigators are very involved in that piece. We have partnerships set up with different transportation agencies that are involved in Polk, Highlands and Hardee County and if a patient has a need for transportation then we pay for that for them and that is also one of the HRSA 19 program requirements, that we provide transportation to our patients if they need it.
- Dr. McMicken – Then the transportation problem should be solved.
- A. Claussen – It should, but it's not. They don't take advantage of it and that's a continuing education process for us.
- W. Murrell – I have a copy of an email from Steve Nierman at Winter Haven that was sent to Dr. McMicken indicating that offering his support for an ER diversion program. The letter says it was going to be presented today and if it was I missed it.
- A. Claussen – That presentation is coming up next.
- D. Zimmerman – For your quality outcome reporting, this would be for population health risk management, when we do a report for diabetes we put the patients' A1Cs in buckets in those categories and we show the migration so if we had 100 people that would be in an A1C 14 or higher we show over the course of the year where they migrated. By showing that migration it

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- D. Zimmerman (cont.) – really does open your eyes to see what you’re doing and I know how hard it is to get diabetic, hypertensive and even the obese people on track. When you show migration, it is showing your quality of care and that you are working with them. That may be something you would want to consider and how you could put that in place.
- A. Claussen – Next time I can present on that, we do track all of our quality as far as the difference and we have to report out. I’ll be happy to show that next time I present.
- Dr. McMicken – Do you think your diabetic medication formula is adequate?
- Dr. Ham-Ying – Our diabetic formulary is wide open, we can obtain anything.
- Dr. McMicken – Can you get Tradjenta, the GOP 1s, or all the new ones?
- Dr. Ham-Ying – We can get all of them, except there is a price associated with everything. Yes, we can obtain it and if we don’t have it in stock at our pharmacy we can have it in a day. There are no limitations as to what we can get.
- Dr. McMicken – You’re not limited to the diabetic medications you can use?
- Dr. Ham-Ying – No, it’s the matter of the person’s access. For example, if a patient’s medication costs \$100, we might be able to provide that at 50% of what retail would be, but it’s still \$50.
- Dr. McMicken – If you want to put a person on Victoza, Bydureon, Tradjenta, or some of the newer drugs you can do that?
- Dr. Ham-Ying – Yes, we have the ability to do that through our formulary, it’s the matter of access for the individual patient.
- H. Vida – On your list of places where you provide dental, you have that you provide dentistry in Mulberry but that’s coming, correct?
- Dr. Ham-Ying – The reason why we say we provide dentistry currently in Mulberry is we received, generously, a couple of dental units on loan from the Hardee Health Department. One of the units is not functional. They’re portable type units a portable unit doesn’t have the high speed hand pieces that will allow us to perform adequate dentistry. We need permanent operatories and full scale operatories. We can do hygiene and seals but that’s about as far as we can go with what we have now. We only have two units and only one is functional; that’s what we are saying that allowed us to see the need was but it’s not allowing us to respond to the need.
- H. Vida – You do have dental care in Frostproof?
- Dr. Ham-Ying – Yes.
- H. Vida – In July, you are opening in Lake Wales for dental, but it’s not currently there?
- Dr. Ham-Ying – We have already a dental site in Lake Wales but we’re opening a new expanded facility on Central Avenue, which is not only going to have dental services but it’s also going to have medical services. We will have 3 medical providers there.
- H. Vida – You also have fulltime dental in Winter Haven?
- Dr. Ham-Ying – That is correct.
- H. Vida – You have dental coming with the funding that you were granted yesterday in Haines City?
- Dr. Ham-Ying – No, the funding that we got will not apply for Haines City. We’re saying that’s our future plans, that we would like to go to Haines City. The funding that we just received will allow us to expand dental in Winter Haven from what it is today.
- H. Vida – How many patients do you see per day in your dental clinics currently and the navigation system that you referred to, call center, are they referring patients to your dental centers or just for primary care?
- B. Fulse – I’m Bernard Fulse the chief financial officer at CFHC. In terms of dental visits, we see about 14 to 15 patients per day.
- H. Vida – Does anybody know what the average is for a dentist to see per day?
- Dr. McMicken – Depends on whether you’re talking prophylaxis and dental hygienist or fillings and crowns. That’s very difficult to determine without seeing what procedures are being done. Simple extraction takes approximately 15 mins, if you’re going to set a person up for crowns or root canals you may not be able to see more than 10 to 15 people per day. Most dental hygienists will see 1 patient every 30 mins and that depends on if they do their administrative work there or at home. With electronic medical records you can spend half your time finishing your medical records after you’ve seen all your patients. It’s not an 8 hour day; it’s a 12 hour day.
- Dr. Ham-Ying – We just changed our electronic record in January from eClinicalWorks to Athena. Athena also upgraded the system a couple of days ago. We will eventually have a better faster system, but right now we had to temporarily drop down our productivity so by Monday we should be back up to full productivity. It has its advantages; the main reason for electronic medical records is for information and clarity. It allows us the ability to electronically prescribe. In regards to quality of care, with the clinical decision support system (CDSS) functions within the electronic record allows us to quickly see what preventative measures are missing and helps us to do a better job of preventative care.

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<p>CFHC Discussion (cont.)</p>	<ul style="list-style-type: none"> ▪ Dr. McMicken – We appreciate your presentation and continue to do the good work and we hope you can get to be even better. ▪ Dr. Ham – Ying – Thank you, we appreciate your support and hopefully we will continue to work together towards the better health of the residents of Polk County.
<p>Emergency Room Diversion Pilot Program Funding Request</p>	<p>Joe Cole, Haley Center Chairman of the Board & CFHC Board Member</p>
<p>Discussion</p>	<ul style="list-style-type: none"> ▪ Presentation given by Joe Cole. ▪ L. Anastasio – What you’re looking at is trying to pilot something that emulates what Dr. Haight at Lakeland Region has done, so when the person presents you’re focusing on the people that have limited requirements at the emergency department (ED) that would be at a lower level equity. Are you talking about transferring them that very first time or treating them the first time and assuring that their continuing care for that same problem would be treated at the Haley Center or CFHC? We’re spending a \$1.5M, as I recall it, at Lakeland to take the people out of the ED and establish a medical home. If we could deal with the free and faith based clinics and in Ann’s operation it seems like we could extend county wide and have a substantial savings, but we are only talking about fairly limited equity patients, you’re not taking high risk patients? ▪ J. Cole – The initial flow diagram would be looking at non-emergent, which would be defined by a physician. As we look at the 60K plus ED visits a year that Winter Haven hospital has had, about 20 to 30% of those are certainly in a non-emergent category. If we look at those people, get the quick non-emergent decision, those people can be sent by this navigator to one of those facilities you just talked about. If you have a hypertension person, who is presenting themselves and they’re not in a critical fashion, you can easily send that person into CFHC or Haley. That person is going to get treated that day for that problem and then the follow along is going to treat the cause and get them in a position where they’re getting better. For the numbers that’s mentioned, I’m going to suggest that you are going to see the savings even though you have to spend money in the hospital, because that does cost a cost to make that decision. I think the cost is going to be substantially well above what CFHC is doing. Their cost, the way that they’re doing it internally, has a tremendous amount of overhead. If you’re doing it externally, it would be less. ▪ L. Anastasio – Dr. Haight told us that it was about \$250 to treat these minor problems in the ED at Lakeland and when they talk to the patient it was roughly \$80 to treat them across the street at the Family Health Center. They also indicated, in their case, that they had the advantage of proximity and he could talk up 3 hours to be seen in the ED or if they go across the street they can be seen in 45 mins to an hour. The continuing care is the payoff. Those people that have a chronic illness are constantly coming back to the ED. If we can better manage them in a medical home, it makes a lot of sense. ▪ J. Cole – That number for those higher end patients that have chronic diseases, according to a study that got facilitated last year in Winter Haven, is roughly \$1000 per visit. You can send that person to CFHC for \$150 for something like hypertension versus \$1000 plus the number of times that person reoccurs. ▪ Dr. McMicken – Most hospitals have a requirement depending upon the acuity with these type people to find them a primary care provider to see within 3 to 5 days of the ED visit. Most of the time, on a rotating basis, different physicians who are on call for different specialties and primary care are responsible for seeing unattached. In Bartow, I get reports from the ED stating that this patient is going to see you in 3 to 5 days and we have to make accommodation for them. I’m sure the same type of thing happens in Lakeland. Most of the time, the hospital social workers navigate that problem and the hospital ED takes care of it. I don’t know what happens at Winter Haven, Lance did you have a similar program at Winter Haven? ▪ L. Anastasio – I’ve been gone for a period of time. It’s more than the social worker, they’re talking about the navigator and trying to get them a medical home and that’s what Dr. Haight spoke so effectively to. ▪ T. Aman – I think this a great program, having worked as an RN in Winter Haven ED back in the late 80’s and early 90’s, one of the burdens on the ED is those non-urgent patients that continuously come or they’re not plugged into a medical home. It’s really an important program. Have you talked to Winter Haven Hospital as far as funding this? Not only would it help the patients to get a primary medical home but also it would be a huge advantage to the hospital to not be burdened with these non-urgent patients while they have traumas and heart attacks and those kinds of things coming in. I certainly validate the program, but I’m questioning the funding because this would be something that Winter Haven Hospital would see the advantage of as well and be willing to fund that position. ▪ J. Cole – For the Pilot Program, after speaking with the executive committee, we looked at what the investment was such as labs, doctors, nurses and someone management wise sitting down and doing some fairly significant policies and procedures and said that’s an investment. The investment in CFHC would be

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<p>Emergency Room Diversion Pilot Program Discussion (cont.)</p>	<ul style="list-style-type: none"> ▪ J. Cole (cont.) – applying an ARNP and also using existing resources and facilities. The investment from Haley Center, for instance, Dr. Threlkeld said they would take 15 patients a day, provide an ARNP, and an administration that goes along with that. For the Pilot Program, the answer is yes, there is an investment for the total program from each of contributors or collaborators. We all felt that it was important that there was roughly a \$30K bill out there for this navigator, which was a legitimate request from the COC, since the others had invested. Secondly, if we take this countywide, the hospitals have a significant reward from doing this kind of project and it's going to save them a tremendous amount of money. I do any statistics and the real costing, we can then go back to these hospitals and say here's what your spending for this many and here's what should be invested to achieve this and your still going to require a savings. Can that all be pushed off on the hospitals? I don't know until we get the data and develop a real plan, but I would hope we would not be back in the COC asking for tremendous amounts of money for a 5 year plan for 5 hospitals. ▪ A. Claussen – Steve Nierman has been very involved and has had a lot of really good meetings discussing this. One of the pieces is the dedication to making it work. With our expansion, adding our second clinic in Winter Haven, that allows us to see more adults in our existing Winter Haven clinic, which will allow us to have that ARNP that's dedicated for this ER diversion program. That's key for you to know. We're not going to wing it and see how it's going to work and that navigator is going to be a CFHC employee that will sit at the hospital. The goal there is when the physician determines that this is a non-emergent patient they'll do that warm handoff to the navigator. The goal of the navigator is to say to that patient, I want to work with you and see what you qualify for and I also want to work with you and talk to you about the fact that CFHC is considered a patient centered home and this is where we want you to come get your treatment and it's not the ED. That's key in the success of it, to have the navigator and patient education. We want to create that patient centered home to keep them out of the hospital for further treatment and visits. ▪ W. Murrell – I've been aware of the development of this program and I'm very supportive of it. If I had a program to develop, it would be this type of program in two formats. In Lakeland, which probably proved to more efficient officially in long term but where the clinic is in house or what is being postulated here, a program where we'd use already existing facilities rather than spending any additional money, especially a large investment, in one location. As we've talked about access, we're better off spending smaller amounts of dollars in more locations, as we service people who are highly immobile. When we look at the Lakeland program we're already funding, as far as Winter Haven funding this, Lakeland with their program to something over \$1M a year. I'm very much in favor of proceeding with this to see if this program can be as effective as Lakeland's has been. Dr. Haight characterized the Lakeland program as a huge success. ▪ Dr. McMicken – It costs a lot of money to be seen in the emergency room, even the fast track, most hospitals for minor stuff they have a fast track the people go through but a lot of those people have a medical home after they go through the fast track so this program certainly has merit. I thought most hospitals were already doing this with their personnel, but apparently they're not. ▪ W. Murrell – We've had a couple of the clinics, either the last meeting or meeting prior, Haines City was saying that they had a loose relationship with Heart of Florida, so I think this is being done. What's important is for us to establish the most efficient procedures to get it done and to look at it as rolling that out throughout the county. ▪ Dr. McMicken – What you're asking for is an additional Pilot Program for \$29K, is that it? ▪ J. Cole – Yes, we're asking the COC to invest with us and then we'll bring together the other resources. ▪ Dr. McMicken – I suggest that we leave our motions; this is up to the Board of course, to the end of the session after we hear our budget presentation and see where we are. At the present time as I read the last budget and upcoming, so far our expenses are exceeding our annual revenues. A lot of it is contingent upon what happens in November with the half cent sales tax of where we're going to be. If we don't get the half cent sales tax passed it's very obvious that in the future there may some programs that are going to have to be reduced. That's just a suggestion; if anybody wants to make a motion about this they are free to do so. We'll probably wait until the end of the session before we decide.
<p>Public Defender Funding Request</p>	<p>Rex Dimmig, Public Defender 10th Judicial Circuit</p>
<p>Discussion</p>	<ul style="list-style-type: none"> ▪ Presentation given by Rex Dimmig. ▪ Dr. McMicken – Was I correct when hearing you when you read the statute that said the people on probation had to be on a psychotropic medication? ▪ R. Dimmig – They don't have to be, it's a portion. If part of their treatment regimen while they're on probation is psychotropic medication, they have to comply with that treatment regimen. ▪ Dr. McMicken – The reason I ask is because one of the major ones, especially in prisons, is basic personality disorder and that doesn't respond to psychotropic medications unless they have other comorbidities and they need really intensive cognitive therapy.

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Public Defender Discussion (cont.)	<ul style="list-style-type: none"> ▪ D. Zimmerman – I want to qualify the expense because on here we’re going to be asked to approve \$115K and what you’re indicating is less than \$50K additional funding? ▪ R. Dimmig – You contribute both to the Public Defenders’ Office and to the Behavioral Health Court System. The Public Defenders’ Office receives \$83K from the IHC fund and what we’re asking for is an increase for our \$83K by \$50K additional dollars.
IHC Budget	Lea Ann Thomas, Deputy County Manager & Joy Johnson, IHC Director
Discussion	<ul style="list-style-type: none"> ▪ Presentation given by Lea Ann Thomas. ▪ Dr. McMicken – Does the purple line include the mandates? ▪ L. Thomas – The mandates are in the red line, that’s the expenses. ▪ Dr. McMicken –The mandates are still going to have to get paid whether the half cent sales tax has any money or if it’s going to have to come from somewhere else? ▪ L. Thomas – Correct, Medicaid and Health Care Responsibility Act will still have to be paid. ▪ Dr. McMicken – The money from the half cent sales tax will be over with in 2021? ▪ L. Thomas – They’ll be over with in December 2019. ▪ Dr. McMicken – I know, but I mean the actual money based upon the reserves. Will there still be money to pay those? ▪ L. Thomas – With the cuts that are in the 5 year plan then the money will last until fiscal year 2020-2021 until June, and that includes the mandates and everything. You can see in the red line a pretty dramatic decrease in the expenses because services will be dramatically cut to keep things going to that last possible referendum. ▪ Dr. McMicken – If we could fund Medicaid from a different source we could last a little longer? ▪ L. Thomas – You can’t do that with the Board of County Commissioners. ▪ Dr. McMicken – I mean Polk County, I’m part of Polk County. ▪ L. Thomas – Yes, obviously the whole program could be funded from another source. ▪ Dr. McMicken – If the the half cent sales tax doesn’t pass, do you have an idea how much property tax would have to be increased to support this program? How much would raise \$39M? ▪ L. Thomas – About \$1.5M, I’m rounding. My suggestion is, one way or the other, whether this referendum passes or not, as the Citizens’ Oversight Committee advisory committee, that we have a strategic planning session. Because of my concerns about expenses outpacing revenues, we need to have a strategic planning session and bring in a facilitator so that you as an advisory committee can say this is where we want our money and how we want to break it down. That hasn’t been done for a long time and I think that this group needs to do that, sit down and really think about how you want to spend your money. We’ve heard a lot of different very valuable programs today and it’s not my decision to make that, it’s yours as an advisory board to make a recommendation to the Board of County Commissioners, to say we want to spend this on mental health, this on primary care, this on specialty care, this on dental or whatever the other options are. My suggestion is that after the referendum, we could do it now but it would be kind of a mood point, either in December or maybe in January whenever the soonest we can schedule it, we can have a strategic planning session so that you can discuss that as a board. We would obviously get ready for it as staff and find a facilitator. ▪ W. Murrell –While we’re on the renewal subject, there is a political action committee, Keep Polk Kids Healthy, which I believe is the first polling of likely Polk voters. They showed a great majority of voters, right at 70% voters, in favor of the renewal of the tax to the extent that the political advisors advise the committee to just sit on your heels. No news is good news; don’t bring anything before the public more than what we need to. Don’t create any problems at this point, that renewal looks very favorable. ▪ Dr. McMicken – I have a question for Ann Claussen, can you find space in your budget for a navigator without us recommending that amount, just for the startup Pilot project? It looks like it is working and I think later on, if we get that half cent sales tax approved, I would be inclined to support a full out, all out county effort; but right now, we need to see where we’re going. ▪ W. Murrell –We’ve pretty much in various areas nationwide, the concept of what’s been proven, we’re proving it and have proved it in Lakeland that’s being funded to the tune of \$1 .25M annually. ▪ Dr. McMicken – That includes a lot more than just a navigator, that includes the whole program. CFHC already has their program in place. ▪ W. Murrell – I understand, it absolutely does but we’re being in rightly so very supportive of that program. I’m not suggesting we change a thing there, but what may happen is it may be able to be proven. Let’s say that Lakeland represents about 50% of the county ED presentations, what may be able to be proven is that the other 50% of the county, the other 50% of the presentations, may

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IHC Budget Discussion (cont.)

- W. Murrell (cont.) – be able to be done at a per case, lower if not much lower, rate of funding from here than what we’re currently doing. It’s difficult when it’s public information; it’s difficult to say this is being funded at \$1.25M and we’re doing that for Lakeland but Winter Haven you guys come up with your own.
- Dr. McMicken – I have no rejection to the project at all and it’s a good project. I was wondering in their overall budget of \$170M if they might not be able to find \$29K for a navigator.
- A. Claussen – I will tell you that we are very passionate to make it work. We’ve got a lot of finances that we are concerned with, opening up two new clinics. Also, what we’re putting in is the ARNP and the front desk staff. On our end, if you look at it that way, were upwards between \$75K to \$100K just if you look at that ARNP and support staff. We’ll work with Winter Haven Hospital if we need to and try to make it work.
- H. Vida – For Jennifer, for a clarification, who will the navigator be working for and would they be a Baycare employee or a CFHC employee?
- J. Voss – A CFHC employee.
- H. Vida – I’m a Baycare employee; I needed to make that clarification so that they would not be receiving funds that I’m voting on.
- Dr. McMicken – Any other questions or comments before we address the budget? Our choices are to vote on the budget as is, the budget with additional funding for Public Defenders’ and CFHC both or one or the other.
- H. Vida – Another clarification, on the CFHC, is there a way to approve one and not the other?
- Dr. McMicken – Yes, you can move that the budget be adoptive with additional funding for both, additional funding for one or the budget as is.
- L. Thomas – If I may clarify, this is an estimated budget. We’ll adjust it based on what you give us direction to do.
- Dr. McMicken – Right. As far as I’m concerned, these are both good programs and I wouldn’t have any problem using our contingency funds to approve them both regardless of what happens in the future. The only problem is this possibly could be changed after November or with our strategic planning meeting depending upon what the projection revenues are going to be and which programs need expanded. Personally, I think we get the most bang for our buck by trying to expand free clinics, because we get more volunteerism that way.
- D. Zimmerman – My concern with both of these, I think they’re excellent programs; however, until we really know what’s going to happen in November and it may look favorable but this is going to be a very strange election year, it’s already setup to be strange. I don’t want to forecast what’s going to happen in November with this half cent sales tax when we may be looking at how we’re going to cut funds. We’re already outspending what we’re bringing in and that’s not a good sign for any board. For us to continue that and even make it worse, I’d rather in January, once we know what happens in November, to look at this and look at our strategic planning to see where it is that we want to put our money. We still need to figure out how we cannot outspend what we’re taking in.
- Dr. McMicken – Is that a motion for the budget as is?
- D. Zimmerman – Yes, it is.
- Motion to approve budget as presented: D. Zimmerman.
- Second: Teri Saunders.
- T. Saunders – Given that this budget is going into effect in October, we’ll have the election soon after and hopefully our strategic planning in January; we’ll still be early into the fiscal year for this budget and that helps me to feel confident. We have some significant decisions to make. Dr. McMicken – The budget can be adjusted during the year even if the half cent sales tax didn’t pass and we looked into our strategic plan and decided that these were important programs for our strategic plan; we can still move to approve them anyway. Isn’t that correct, Lea Ann?
- L. Thomas – Yes.
- W. Murrell – I’m not sure if it was brought out earlier, but one of the considerations for the ED offset program was that the program be started in October and it was done that way so that the program could move into season, not start in the middle of the throng of things in January, so that there would be time to get it in place. Again, I’m still very much in favor of that. What the political committee has already spent money to find out, we appear to be in great shape there to the extent that there’s nothing being done to promote the continuation at this point because they have suggested it’s not necessary.
- Dr. McMicken – I understand and I’m willing to go with that personally myself, if you want to do the budget with the addition of the navigator then your vote for this motion should be no.
- Dr. Young – I’m the eternal optimist, I’m looking at this and what we’d do if we didn’t have to

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<p>IHC Budget Discussion (cont.)</p>	<ul style="list-style-type: none"> ▪ Dr. Young (cont.) – make a decision later on and if we have to we can change the budget, we can drop things. I’m in awe of the presentations and I’m excited about the things that are coming down the pipe. I’d like to see them all continue right now. It would actually be a positive thing for talking about continuing the half cent sales tax which is what we’re dealing with basically, and I propose that we support it. ▪ Dr. McMicken – We have a motion on the floor, we will have to vote on the motion first but that is a good portion of discussion. If you agree with Dr. Young, this motion should be voted down. ▪ K. Andrews – For clarification, this motion doesn’t include the piece for the navigator, correct? ▪ Dr. McMicken – This motion doesn’t include either one of those pieces, its budget as presented. If you want to include either one of those two pieces this motion needs to fail. The motion is to approve the budget as presented. All in favor say AYE and raise your hand. ▪ Committee voted: AYE: D. Zimmerman, H. Vida, Dr. McMicken, D. Moses, T. Aman and T. Saunders. NAY: W. Murrell, K. Andrews, L. Anastasio and Dr. Young (6 AYE – 4 NAY). ▪ Dr. McMicken –Motion for Budget as is passes, 6 to 4. ▪ Dr. Young – Do we have a chance to approve the CFHC or Public Defenders’ Office requests? ▪ Dr. McMicken – We will have a chance at any meeting in the future to go back and address this again and approve it then. When we have our strategic planning meeting we need to address all of the things that we do and where we think we best benefit and, of course, the indigent population we serve. One thing that I would like us to conserve or even have a discussion with the County Commission at some point is if they can figure out a way to meet the Medicaid mandate by some other means. It would give us a lot more money to be able to spend for indigent healthcare. Of course, Medicaid is indigent healthcare and it may lead to stay the same as it is, but we can have a discussion. Until a couple of years ago the Medicaid payment was never included in the half cent sales tax and that only started about 2 or 3 years ago. At that time, the COC Board voted not to include Medicaid but the BOCC didn’t. ▪ L. Thomas – It was a close vote and the COC voted to include it. ▪ Dr. McMicken – I’m corrected. Anything else to come before the board? Joy Johnson, you will be speaking with us about setting up a future strategic planning meeting? ▪ J. Johnson – Yes.
<p>Final Comments</p>	
	<ul style="list-style-type: none"> ▪ Motion to adjourn meeting: H. Vida ▪ Second: L. Anastasio ▪ Meeting adjourned.
<p>Transcribed by</p>	<p>Indigent Health Care Division – Stacy Craver</p>
<p>Special Notes</p>	<p>Next COC Meeting: July’s meeting was cancelled due to no new business. Meeting scheduled for August 19, 2016</p>