County of San Diego

HEALTH SERVICES ADVISORY BOARD

1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

Thursday, February 21, 4:00 - 6:00 pm
1600 Pacific Highway, Room 302/303
San Diego, CA 92101

MEETING MINUTES

Members Present	Members Absent	Presenters	HHSA Support Staff
Judith Shaplin, Chair Ben Medina Bob Prath Estelle Wolf Jack Rogers James Beaubeaux John Sturm Judith Yates Leonard Kornreich Michelle Bray Davis Steve O'Kane	James Lepanto Adiana Andres-Paulson Steven Escoboza (Excused) Robert Hertzka (Excused) Dennis Holz (Excused) Greg Knoll (Excused) Colin Mackinnon	Dr. Roneet Lev Dr. Eric McDonald Peter Shih	Wilma Wooten Linda Lake Angela Hawley

Issue	Discussion	Action
1. WELCOME – Judith Shaplin, Chair		
	The meeting was brought to order at 4:05 pm. Judith announced that all HSAB members have to complete the Ethics Training every two years. The last training occurred in June 2011 so renewals will be coming up soon. Linda Lake will send out the Ethics document with a link to the training soon. Once completed, certificates can be sent to Angela Hawley (Angela.Hawley@sdcounty.ca.gov). Members who have already completed the training for another committee do not need to re-take training; please send certificate to Angela Hawley.	
2. PUBLIC COMMENTS		
• Public Comment	There was no public comment.	

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3. PRESENTATION/DISCUSSIONS		
Approval of Minutes		
	There are two corrections to the January minutes. Michelle Bray Davis was not present at the January meeting and minutes should reflect that she was excused. It was also announced that if alternates are present at the meeting, the representatives do not need to be listed as 'excused'. Judith motioned that the minutes from January 17, 2012 be approved with the above listed corrections. James Beaubeaux motioned to approve the January 17, 2013 minutes. Steve O'Kane seconded the motion.	**All in Favor.** **Motion passed.**
• Prescription Drug Abuse Task Force	Dr. Roneet Lev and Dr. Eric McDonald presented information on the Prescription Drug Abuse Task Force and the epidemic of prescription drug abuse in San Diego County and the nation. Handouts were included in the packet. Dr. Lev presented the Safe Pain Medication Prescription Guidelines and the Safe Pain Medicine Prescribing in the Emergency Department flyer. Dr. Lev is asking for endorsement/approval from the HSAB committee so that the County of San Diego HHSA logo can be put on the flyer. With the endorsement, it will be easier to have the same kinds of signs, language, and standard throughout all emergency departments in San Diego and in Imperial County and the same guidelines and pain agreement for practitioners in San Diego. Patients will be provided this information on the rules for treating pain before they even see a doctor. ***Questions and Comments*** *Q1 - What is the motivation for the emergency departments to prescribe medicine? Does the hospital/emergency room pharmacy have some kind of financial incentive to get medications out of the door?* The motivation is cultural. During my	**Linda Lake will distribute contact information for the Task Force and members.**

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	residency, we were taught that emergency doctors do not treat pain well enough. We were trained to treat pain more; asking what level of pain are you in, what is your pain, when a patient is there for pain we need to get them a pain prescription. There is no financial incentive. *C1 - This information looks good, but I'm not sure this is the best way to spend our money, energy, or time.* This is a large cultural issue. One piece of the pie is not going to fix it. There are many ends; addiction, desire, and education. We are just taking a little piece of what the medical community can do about this and seeing how we can change it. We would like to get all providers to have access to the Controlled Substance Utilization Review and Evaluation System (CURES) in order to better monitor the medications that are prescribed to a patient. *Q2 - How do we mandate this process so that it's a part of the culture rather than a volunteer process? Also, how do we get ER doctors to monitor this process instead of just wanting to take care of the patient?* This is what this program is about. We cannot mandate anything and we are not asking to mandate. We are asking for a culture change. Having these signs and brochures out in emergency rooms will help with the change. *Q3 - It was mentioned that by having signs out, patients will know what doctors will and won't do. Patients will now know how to lie better to their doctors when requesting pain medications.* Dr. McDonald commented that this is a much needed effort. From being involved in the process, the changes that have already occurred at various hospitals have been what accumulated to the culture change that we are asking for. This is a not a high cost intervention;	

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	in fact, it is low cost with a high impact. Just from lowering doses from 30 to 15 pills (for example) can make a significant impact. *Q4 - It is a concern that teenagers have more access to left over medications. Did the issue of teenage deaths and overdoses come up as you were going along with your project?* Dr. Lev shared that the number one prescriber of teenagers are the emergency doctors and the dentists. Both are participating on our coalition and we do need to treat those issues as well. The County's Prescription Drug Abuse Task Force has been meeting since 2008 and most of their efforts and meetings are about the teenage problems and access. Dr. Lev has now been added to their executive team as the medical person and will soon learn more about this problem. *C2 - Physicians should have the responsibly to talk to their patients and remind them that any medications should be locked up.* Information on locking up medications can be added to the guidelines. *Q5 - Is there information on the number of deaths broken down by the combination of drugs?* Page 5 of the PowerPoint has information on the deaths in San Diego. The information is not broken down by the specific drugs. Dr. Lev can get that data from Dr. Lucas (Coroner). He has it by the number of drugs, the age group, etc. *C3 - It should be educated to the consumer that the doctor is going to provide a lower number of medication, rather than prescribing the larger supply of pain meds. I think people would like to make sure that they will not have to jump through hoops to get another prescription for pain meds if it is appropriately needed.*	

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	30 is not the standard number of pills that a doctor normally prescribes; it's actually less than that. But regardless, the patient should always receive follow up care for whatever problem they are being seen for. *C4 - There is a current program that focuses on taking back prescription drugs which is a huge component. All hospitals should have drop boxes. There should also be education to children on medications, especially when they see their parents taking medications. They are not aware of the complications and differences between all the types of medications.* *Q7 - The impression I have is that this is changing the way that health care providers write prescriptions. Since there is something that the patient is going to sign, what is the action taken if the patient doesn't comply?* If they break the agreement, they will get a referral for addiction treatment if that's appropriate. However, there is no way to mandate that (unless you suspect Doctor shopping and the DEA gets involved). *C5 – For the next 'to dos" Dr. Wooten requests for this program to look at Adderall and its effect on college students. Students are using this drug in increased prevalence now; going to the doctor and faking out symptoms to get prescriptions. If it's possible, can this be a possible targeted campaign in the future?* This has come up from our psychiatrist and community physicians and it was decided that it would be easier to come to this institution with the focus only on pain, then allow the psychiatrist or any other physician to change the wording on the Patient Pain Medication Agreement and Consent to 'any medications' because this form really applies to everything.	

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	C6 – In regards to access to the CURES report, physicians are the only ones who can have access. It would be very helpful if staff can have administrative access. Doctors are too busy to look this up and the admin staff are the ones that know which patients are problematic; but we don't have access. The CURES report is a critical component of monitoring their access to medication. You're absolutely right. Having someone else running this report is very helpful. In the emergency department, the pharmacists have access to CURES in addition to the doctors so that helps a lot. However, in community clinics, this is not the case. Also, we need more prescribers to have access to this system. It is not easy to get access and can take up to 6 months. The CURES people are coming to San Diego on April 12, 2013 for a campaign for the community physicians. Physicians will be able to get signed up at the CURES booth. We also want Balboa hospital and the VA to have access to this system too. In order for them to adopt the program, it will need to be elevated to Washington DC to make that decision. The Medical Society will have today's PowerPoint available on their website in addition to other information. The County Prescription Drug Abuse Task Force will soon develop a website and all this information will be available. The HSAB website will also have this information available. *Q8 – In terms of intentional vs. unintentional, do we have any understanding whether it's the long term patients who are experiencing long term pain issue or the other people who are overdosing? Is there any information separating this out?* I have that data based on ages and pills but not on chronic diagnosis. This data comes from the medical examiners officer so the determination of intentional vs. unintentional is based on the investigation of those. Since this agenda item/presentation is requesting	

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	approval from HSAB, this item must be moved to an Action Item for the March HSAB meeting. After HSAB approval, this item will be taken to Nick Macchione for support. Dr. Roneet Lev and Dr. McDonald will submit a proposal for HSAB to review.	
• Community Based Care Transitions Program (CCTP) – Brenda Schmitthenner	Brenda Schmitthenner presented a PowerPoint on the San Diego Care Transition Partnership (SDCTP). Handouts were included in the packets. Background information was provided to show how Aging and Independence Service (AIS) became a recipient of the Community Based Care Transitions Program. The goals of this program are to improve transitions of beneficiaries from inpatient hospital settings to the home or other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program. The partnerships are between HHSA/AIS, Palomar Health, Scripps Health, Sharp HealthCare and UCSD Health System – 13 hospitals. CCTP rolled out in January 2013 and will have all hospitals on board by April 2013. ***<u>Questions and Comments</u>*** *Q1 - Are any of these clients homeless or severely mentally ill?* Each of the hospitals has targeting criteria and all of the patients are Fee-For-Service Medicare. Being homeless would not preclude a client from participating as long as they met the targeting criteria for that health system. *Q2 – Can you provide an example of what you are offering these clients? Are you offering in home services or nurses for clients that don't want to be cared for in the hospital settings?* The money that is provided for this program is for the hospitals to provide the interventions mentioned in the PowerPoint. The money is	

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	aimed at providing services for high risk patients that are beyond the conditions of participation within the health system. The partnership with AIS is to provide transition care service within the two health systems and then to provide the social service partnership to really high risk patients who lack the social support. *Q3 - In making the decision about 30 days after discharge, is that a statistically significant length of time, a convenient length of time, or an affordable length of time.* It's in the statute. The program is only for 30 days after discharge. They are trying to impact the 30 day readmission rate. The thought is to test models that really provide improved transition services that would impact the 30 day re-admission rate. *Q4 - Some of the primary causes of re-admission seem to be beyond the scope of we can reasonable handle. But regarding the inadequate hand-off to downstream providers within hospital systems, what is that related to? The system, the family, insurance?* The biggest indicator is that the primary care physician has no idea what is happening with their patient in the hospital. Information provided to the primary care physician can mitigate this problem as well as hospitals by arranging a follow up visit to the primary care physician before the person is discharged. *Q5 - Based on the pilot program, there is potentially over $100 million in savings to Medicare. How does that get spread out?* The cost savings go back to Medicare. One of the goals of the program is to create cost savings and reduce Medicare costs.	
• Healthy Families Transition Update – Peter	Peter Shih provided an update on Phase 1 which was implemented January 2, 2013. As of today,	

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Shih	43,000 individuals have been transferred from Healthy Families to a Managed Care Medi-Cal Program. Phase 1B will transition approximately 6,000 people starting March 1, 2013. Phase 1C is for Health Net members which will convert on April 1, 2013. The remaining phases are on target. Phase 3 is the Blue Cross members and is scheduled to convert in August 2013. There are approximately 12,000 converting. Access has not identified any impact to their call volume. So far this has been a seamless transition although this cannot be confirmed until all individuals are converted. Peter also shared information about the Targeted Low Income Children's Program (TLICP). This program raises income limits for no-cost and premium-based Medi-Cal which includes all Healthy Families income parameters. Their FPL range is 150 - 250. This is an asset waiver program which follows all FPL program eligibility rules and increases FPL limits for kids ages 0-19. It does implement a premium requirement for kids with income over 150 FPL. Children with a share of cost will fall into the new income limits and can qualify for this new program with no share of cost or premium requirement. ***<u>Questions and Comments</u>*** *Q1 – The 60-day letters should have gone out in February in regards to the April 1st transition and people are saying that those letters have not gone out yet. Can you check on that?* *Q2 – I am concerned with those that did not enroll? Is there any information as to why?* We are at the mercy of the State as they are giving us the information. The plans are suppose to be keeping track of these patients. We believe everyone is receiving care; they are just not in the Medi-Cal count. *Q3 – For those that are transitioning, they have already paid Medi-Cal for the year. I've been told that these people are aware that they have to pay again. If they don't pay, they will get dropped from*	

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	Medi-Cal. How are you addressing that? Greg Knoll is on top of this issue. This is an advocacy issue and is a huge concern. These people have already paid once and they do not have the money to pay again.	
• Automatic Prescription Refills – Dr. Ben Medina	Dr. Ben Medina shared information on the problems with automatic prescription refills and the effects on patients. Pharmacies are continuing to refill old prescriptions that may have changed over time or have been canceled by the doctor. This issue needs to be brought up to the Board of Pharmacy. Estelle Wolf will be going up to Sacramento soon and will bring up this issue. She will provide an update once she receives feedback.	
4. ACTION ITEMS		
	There are no action items for this meeting	
5. PUBLIC HEALTH OFFICER'S REPORT		
• Wilma Wooten, M.D., M.P.H.	Dr. Wooten introduced Dan O'Shea as the new Public Health Administrator. Handouts were provided regarding this season's influenza activity. **Board Letters** • EMS Ambulance ordinance – March 2013. • Application for PH Accreditation –April 2013 **Legislative Updates** Health Officers Association of California (HOAC) does tracking of pertinent health care bills. A summary was provided of 19 bills. ***Questions and Comments*** *C1 – During the holiday season, I visited my doctor to get my flu shot and I noticed there were no signs or educational material about the flu. Nobody even asked me about it or if I wanted one.*	

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	Dr. Wooten responded that this is a good recommendation and for next year's flu season the County can develop a one page flyer and tools to send to the community clinics to post. We will be bringing an issue back to this advisory board from the GERM (Group to Eradicate Resistant Microorganisms) Commission regarding mandatory vaccinations for next year's flu season. This would involve hospitals and healthcare facilities and may be extended to long term care facilities. In a previous year, there was legislation that required all heath care professionals/staff to either get the flu shot or wear a mask. This bill failed and wearing a mask was one of the primary issues; however, this may be reintroduced. *Q1 – Apparently there is a senior dose for the flu shot, is it well known that seniors are supposed to get a different shot?* It has been available for about two years but the uptake has not been very great. We should explore if we should do an increase of education considering the number of deaths San Diego has had. It is double the dose with an effectiveness of 59%.	
6. AGENDA ITEMS – March 21, 2013 MEETING		
	(These are suggested agenda items based on presenters availability) • Action Item: HSAB support for the Safe Pain Medicine Prescribing in the Emergency Department flyer – Dr. Lev • Beacon Presentation – Dr. McDonald • Healthcare Reform • Healthcare Exchange – nothing has been developed yet but they are in the process • Weapons Reporting Requirements	
7. ADJOURNMENT		
	With no other business, Judith Shaplin motioned to adjourn this meeting.	