



Carlos A. Migoya
President & Chief Executive Officer

TO: Honorable Joe ~~A. Martinez~~, Chairman
and Members, Board of County Commissioners

FROM: Carlos A. Migoya
President & Chief Executive Officer

DATE: February 9, 2012

RE: Primary Care Clinics

Providing for the health and wellness of Miami-Dade County's residents is a central part of Jackson Health System's mission. The changing nature of the American healthcare system, the South Florida medical marketplace and contemporary research on best practices are all pushing care toward preventive and outpatient paradigms based in neighborhood clinics. As part of our developing strategic plan and our consideration of the guidance in Resolution R-561-11, we have prepared this report regarding the feasibility and fiscal impact of converting real estate controlled by the County or the Public Health Trust (PHT) into primary care clinics.

Jackson was a collaborative partner with the Miami-Dade County Safety Net Providers, Miami-Dade County Office of Countywide Healthcare Planning and the Miami-Dade County Health Department in the development and publication of the Primary and Dental Care Needs Assessment of 2010-2011. The primary objective of the report was to provide an understanding of the essential clinical services lacking within Miami-Dade County.

The directive received through Resolution R-567-11 assumes that "increased primary care will result in fewer emergency room visits at the Jackson main campus," and further assumes that "primary care clinics are a revenue generating endeavor that will contribute to the PHT's financial recovery," and that the available County- and PHT-owned, leased or managed real estate sits in a medically needy, appropriately zoned site, appropriate for the provision of clinical services. Following is a summary of the needs assessment report.

Demographics

Population

Miami-Dade is the largest county in Florida. In 2009, the population reached approximately 2,467,057 people, 51 percent female, with 25 percent under the age of 18, and 61 percent between the ages of 19 and 64.5 (See Appendix A). In 2008, the Office of the Governor reported the racial composition of county residents to be approximately 76.9 percent white, 20.9 percent black, and 2.2 percent other. Miami-Dade County is unique in its ethnic make-up, with over 63.2 percent of county residents reporting Hispanic origins, compared to 21.4

percent statewide. The majority (68 percent) of residents speak a language other than English at home. Additionally, the 2000 U.S. Census reported that half of Miami-Dade County residents were foreign born.

Poverty Level

The 2000 Census estimated that 18 percent of Miami-Dade residents were at or below the federal poverty level, compared to 12.5 percent statewide. Additionally, 49 percent of county residents are at or below 200 percent of the federal poverty level, another important demographic indicator, compared with 31 percent statewide. Considering Miami-Dade's relatively high cost of living, this provides important context into the share of our residents who face significant economic challenges. This is also reflected in another nationally used indicator: in Miami-Dade County, 68 percent of elementary school children and 65 percent of middle school children are eligible for free or reduced cost lunches compared to statewide levels of 55 percent and 50 percent respectively during the 2008-09 school year.

Uninsured

There are approximately 646,378 uninsured residents under the age of 65 in Miami-Dade County. In 2010, the federal government estimated that 28 percent of the County's civilian, non-institutionalized population did not have health insurance coverage. Small Area Health Insurance Estimates produced by the Census for 2006 estimated that 53 percent of the uninsured – more than 325,000 people – were below 200 percent of the federal poverty level.

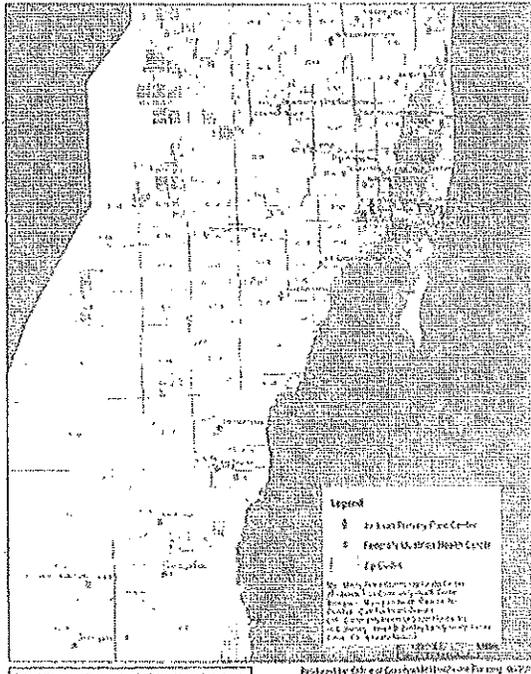
A distribution of the uninsured by zip code was facilitated by the 2003 Florida Health Insurance Study. In order to provide the best estimate of the uninsured by zip code, the percent uninsured in each zip code that was estimated in 2003 was applied to the estimated population in each zip code in 2010. That formula shows the uninsured population is spread widely across the county, with highest concentrations in the north (zip codes 33016, 33015, 33055 and 33012), in central Miami-Dade surrounding Liberty City, (zip codes 33142 and 33147), in Sweetwater (zip codes 33175, 33165) and to the south (zip codes 33186 and 33033).

Applied to Miami-Dade County in 2012, this equates to an additional 8,980 adults age 19-64 for every 1% increase in the unemployment rate.

Access

The Miami-Dade County safety net delivery system includes resources not present in many other geographic regions of our state, as shown on the following map.

Primary Care Safety-Net, Miami-Dade County
Federally Qualified Health Care Centers, FQHC Primary Care Centers

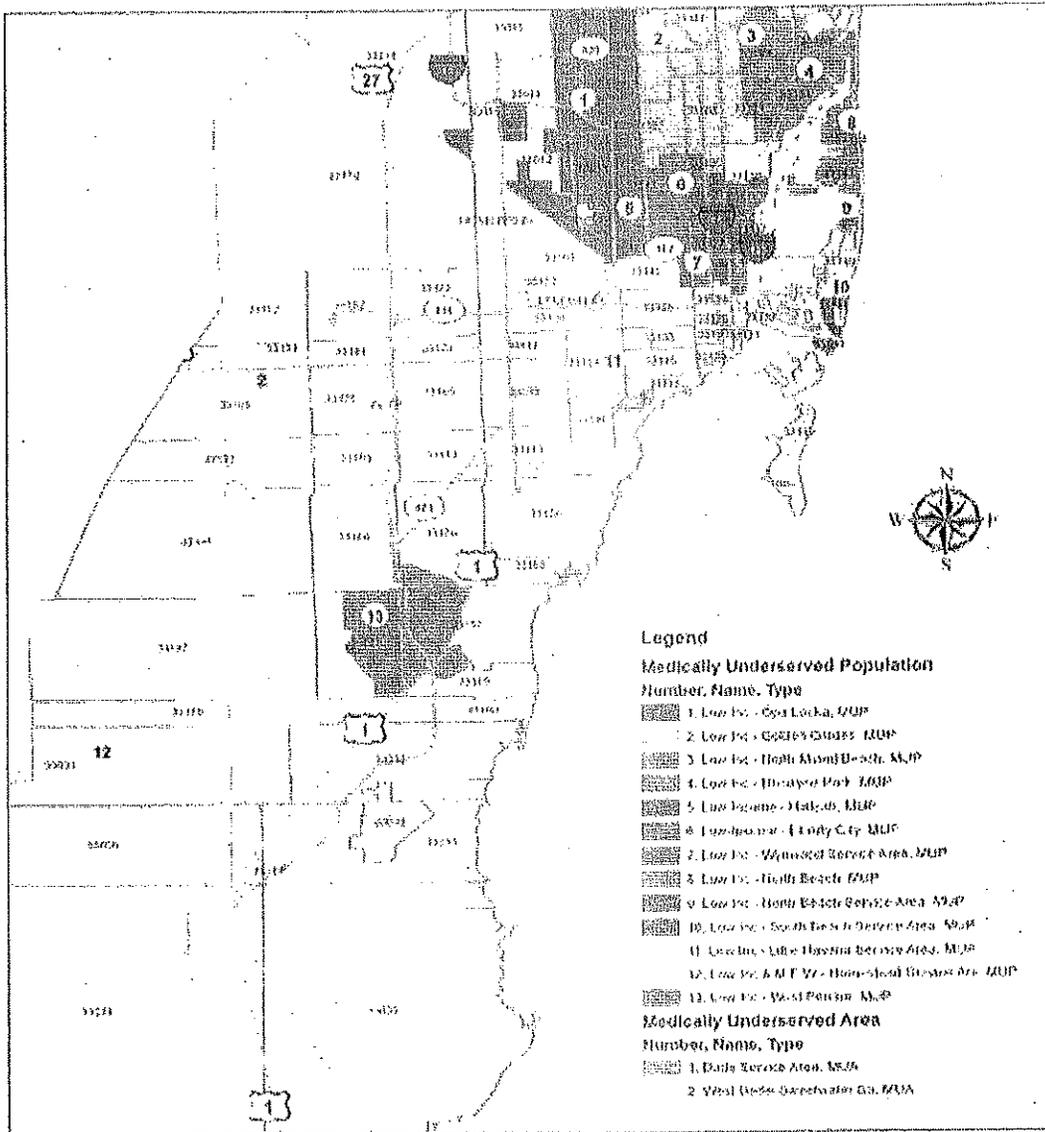


The resources include:

- Jackson Health System's three primary care centers;
- Four other hospital systems who participate in the safety net;
- Seven federally qualified health centers (FQHC), with 21 sites for primary care services;
- Seven free clinic sites;
- 131 Health Connect In Our Schools sites, managed by the Children's Trust and operated by contract providers, including Jackson; and
- Medical schools at the University of Miami and Florida International University.

The County has approximately one licensed primary care physician for every 1,528 residents. However, there are 12 areas composed of 180 census tracts that are designated as having Medically Underserved Populations where that ratio falls to approximately one primary care provider for every 3,000 residents. In addition, there are two locations designated as Medically Underserved Areas where there is less than one primary care physician for each 3,500 county residents. These geographic regions represent large and dense concentrations of uninsured residents and Medicaid enrollees with limited access to primary care and dental services. Those areas are shown on the following map.

Medically Underserved Designations in Miami-Dade County



Data Courtesy: U.S. Department of Health and Human Services

Disparities in Essential Clinical Services

Inpatient data for Miami-Dade County was obtained from the Applied Epidemiology and Research Unit in the Office of Epidemiology, Disease Control and Immunization Services of the Miami-Dade County Health Department, and statewide hospitalization data was provided by the Chronic Disease Evaluation and Surveillance Unit of the Florida Department of Health Bureau of Epidemiology. This data was also presented in the Miami-Dade County Primary Care and Dental Needs Assessment.

Thirty-one health indicators were presented, categorized into the following six sections:

1. Diabetes
2. Cardiovascular diseases
3. Cancer
4. Prenatal and perinatal health
5. Child health
6. Behavioral and oral health

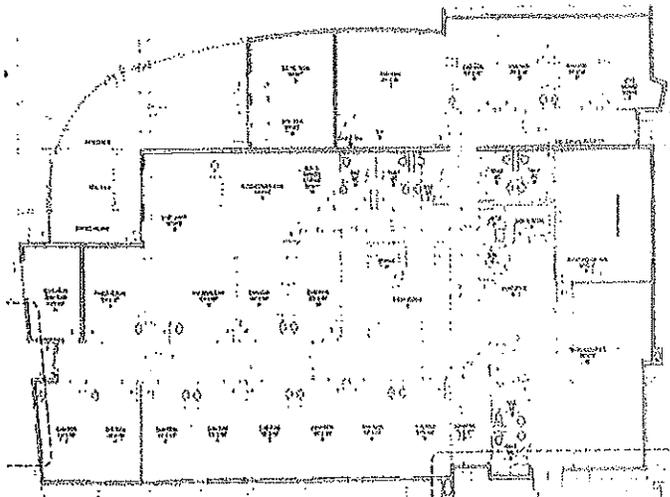
Miami-Dade County's outcomes were worse than statewide levels in 15 of the 31 health indicators. Those indicators reflecting the least favorable outcomes were:

1. Diabetes
2. Hypertension
3. Congestive Heart Failure
4. Adult Admission Rates
5. Pediatric Admission Rates
6. Youth Suicide Attempt
7. HIV/AIDS

Jackson's three primary-care clinics reflected a higher rate of diabetic patients, asthmatic patients, and hypertensive patients compared to the total patient population (25.7 percent, 4.7 percent, and 52.1 percent, respectively), than Miami-Dade County FQHCs (4.4 percent, 1.7 percent, and 8.8 percent, respectively).

Feasibility of New Jackson Clinics

Jackson has previously explored the creation of additional primary care clinics, whether through conversion of existing facilities or obtaining new ones. In almost any case, substantial capital investments are needed to outfit a site for medical use, in addition to obtaining proper zoning and other regulatory clearances. The following diagram shows a sample facility requirement to provide the appropriate service level.



Nonetheless, Jackson and its partners on the Board of County Commissioners have been able to identify the capital resources necessary for such projects. The far greater challenge surrounds operating costs. We conducted a new five-year analysis of the likely costs and revenues associated with a new primary-care clinic.

We estimate first year losses of more than \$1.3 million, escalating annually for a projected five-year loss of \$9.1 million. Details are shown in the following table.

	TOTAL YEAR 1	TOTAL YEAR 2	TOTAL YEAR 3	TOTAL YEAR 4	TOTAL YEAR 5	FIVE-YEAR TOTALS
REVENUE						
TOTAL REVENUE	\$ 2,462,335	\$ 3,221,832	\$ 4,298,956	\$ 6,370,942	\$ 7,622,525	\$22,876,690
SUB-TOTAL SALARIES+ BENEFITS	\$ 986,232	\$ 1,015,819	\$ 1,381,107	\$ 1,422,545	\$ 1,465,215	6,270,918
SUB-TOTAL PURCHASED SERVICES	\$ 1,645,625	\$ 2,118,615	\$ 2,804,820	\$ 3,401,025	\$ 4,869,435	14,929,520
SUB-TOTAL SUPPLIES	\$ 317,977	\$ 416,438	\$ 555,252	\$ 694,065	\$ 971,691	2,955,423
TOTAL DIRECT EXPENSES	\$ 2,755,588	\$ 3,348,742	\$ 4,539,049	\$ 5,408,605	\$ 7,104,211	23,153,095
ESTIMATED INDIRECT EXPENSES	\$ 1,055,390	\$ 1,282,568	\$ 1,738,456	\$ 2,070,308	\$ 2,720,913	8,867,635
CONTRIBUTION LESS INDIRECT EXP	\$ (293,253)	\$ (126,910)	\$ (240,093)	\$ (34,663)	\$ 418,314	(276,505)
NET CONTRIBUTION + OH	\$ (1,348,643)	\$ (1,409,478)	\$ (1,978,549)	\$ (2,104,872)	\$ (2,302,599)	(9,144,140)

Discussion, Conclusions and Recommendations

Providing high-quality and accessible outpatient care programs presents a number of challenges. The outpatient market is typically more crowded than the inpatient market, with physician and for-profit niche providers competing with hospitals, retail service centers, ambulatory service centers and physician groups for a piece of the eroding market share. Copayment policies have historically encouraged the migration of unfunded services to Jackson's primary-care settings, as demonstrated by the volume patterns of outpatient services to Jackson's three primary care clinics rather than to the community's FQHC's.

There are also reimbursement pressures as payers seek to manage the use of outpatient services more effectively and reward organizations that provide high-quality care. A greater number of outpatient services are being bundled into a single payment; for example, hospital-based payments for image-guided radiation therapy eliminated separate reimbursement for imaging guidance. Pay-for-performance methodologies require hospitals to meet a variety of quality measures to avoid reduced payments. The rapidly shifting legislative and regulatory environment makes it difficult to predict the fiscal impact of this payment reform on our already underperforming practices.

As it stands today, Jackson faces challenges in managing and delivering primary care in a cost-effective and customer-focused manner. Retrofitting regulated practice environments into spaces originally designed for

other purposes may result in inefficiencies. Adapting operational and information systems will also present a challenge for Jackson and would strain the already fiscally strapped budget.

Jackson currently has market penetration in two of the areas identified as medically needy. The third location is the Sweetwater region, where Florida International University is using the neighborhood access plan to improve access and utilization.

There is no question that Jackson's strategic future must be built around improved penetration and access for primary care. Such a move is in the best interest of both community wellness and Jackson's long-term success. As we will begin discussing in earnest this spring, we believe there are more contemporary and efficient ways to provide more and better access to primary care without creating unsustainable new expenses.

Market competition demands that we carefully moderate public discussion of these strategies, but we expect to provide increasingly detailed roadmaps of these initiatives in the coming weeks and months. Rest assured that our transformation plan for Jackson is built around increasing access, improving service and growing our support to neighborhoods across the economic, demographic and geographic spectre.

We look forward to sharing these plans and achieving these vital goals for our residents and for Jackson as the community's taxpayer-owned leader in health and medicine. If you have any questions, please do not hesitate to call me.