

HEALTH CARE ADVISORY BOARD

Meeting Summary

May 13, 2013

MEMBERS PRESENT

Marlene Blum, Chairman
Rose Chu, Vice Chairman
Bill Finerfrock, Vice Chairman
Dr. Tim Yarboro
Ann Zuvekas
Ellyn Crawford
Judith Beattie
Francine Jupiter
Rosanne Rodillo
Dave West
Dr. Michael C. Trahos, DO

STAFF

Sherryn Craig

GUESTS

Vera C. Dvorak, MD, Inova Health System
Robert Hager, Inova Health System
Anne Rieger, Inova Health System
Michael Forehand, Inova Health System
Gloria Addo-Ayensu, MD, MPH, Health Department
Rosalyn Foroobar, Health Department
Chris Stevens, Health Department
Dr. Jean Glossa, Molina Healthcare
Dr. Tom Dotson, VP of Communications, Birmingham Green

Call to Order

The meeting was called to order by Marlene Blum at 7:34 p.m.

March Meeting Summary

The minutes from the April 8, 2013 meeting were accepted as submitted.

Inova Integrated Transitional Care Management (TCM) Program

Dr. Dvorak, Medical Director for Inova's Integrated Transitional Care, provided a program update. The definition for the program has been changed as there is no traditional discharge process. She characterized discharge as a relay, passing the baton with all health related information among patients, nurses, caregivers, physicians, pharmacists, clinics, community services, FQHC, home services, and SNFs. Program goals include reducing duplication of services, improving decision support, teaching patients and caregivers chronic disease management, and increasing high patient satisfaction. What has been missing in the traditional discharge process is feedback between medical and discharge staff. This has contributed to issues regarding quality

discharge treatment plans, individualized treatment plans, medication affordability, and understanding diagnoses.

As a result, the TCM program includes Inova hospitalist oversight 20 hours per week on site. TCM actively recruits and refers patients with Chronic Heart Failure (CHF), Diabetes, Chronic Obstructive Pulmonary Disease (COPD)/Pneumonia, and Complex Medical Diseases without private health insurance. Payer types include unmanaged Medicare, unmanaged Medicaid, and the uninsured. The program receives referrals from inpatient and observation admissions, the emergency department (ED), TCM screeners, hospital case managers, and others. In addition to patients with commercial insurance, TCM does not enroll SNF/ALF residents, patients with End Stage Renal Disease (ESRD) or in hospice.

The program is organized under the same EVP and VP reporting structure as hospital case managers, home health, palliative care, safety net clinics, PACE, and community health. The TCM medical director is onsite and responsible for care coordination, TCM, palliative care, and weekly rounds. The program structure has resulted in seamless communication, improved coordination, and strong collaboration.

The home visits component of the program uses Inova VNA Home Health to provide 1-3 non-skilled home visits as needed. A non-skilled visit includes an assessment of the home or an evaluation of medications; patients are not examined.

TCM staff also work with existing nurse staffing/scheduling and hospital liaisons. TCM leverages partnerships in the community, including safety net clinics, the Area Agency on Aging (AAA), and SNF Collaborative.

Dr. Dvorak reported March – December 2012 program outcomes. Fifty-two percent of patients referred to TCM were being treated for diabetes, followed by 17% with COPD. The payer mix was 57% Medicare, 40% uninsured, and 3% Medicaid. TCM admissions by patient status include inpatient admissions (77%), ED (15%), and observation admissions (8%). TCM's referral distribution includes TCM case managers (71%), inpatient case managers (28%), and other (1%). Of the 105 ED patients referred into TCM and who stayed in the program for 28 days or more, none were readmitted into the ED. Half of the TCM patients who drop out of the program are readmitted; readmission remains consistent across payer source and disease category. In total, more than 2000 referrals were made to the TCM program and 984 stayed with the program 28 days. The readmission rate among TCM patients who stayed in the program for 28 days is 3.9%.

While some patients drop out, others cannot be contacted. TCM's staff try to engage people in the hospital face to face. TCM has partnered with Johns Hopkins University to study which factors may contribute to patients deciding not to participate. Despite program attrition, TCM has demonstrated considerable progress.

The program has collected baseline data that matches a set of patients (disease category, payer source, etc.) who were admitted before the program was offered. Readmission rates at baseline were 13-16%. The goal of TCM was to lower that rate by 2% in its first year. TCM exceeded that goal in year one and exceeded it again in year two.

Program of All-inclusive Care for the Elderly (PACE)

Robert Hager, Assistant Vice President, Long Term Care Services and Program Director, InovaCares for Seniors PACE, updated the HCAB on InovaCares for Seniors PACE Program. The program enrolled its first participant on May 1, 2012. The grand opening occurred on June 7 at the former Braddock Glen Adult Day Health Care (ADHC) Center.

The Centers for Medicare and Medicaid Services (CMS) conducted a site visit last week. The program has a 3 year technical advisory relationship with federal and state agencies.

From May – September 2012, the program grew from 0 to 7 participants. Participation increased 185% from 7 to 20 participants from September – December 2012. As of April 1, 2013, the program has enrolled 31 participants. One of the program's constraints is that participants can only be enrolled on the first day of the month.

Participants include 19 women and 12 men. The age distribution includes eight participants who are 65 years of age or younger, 19 who are 65-90 years old, and four who are over 90 years old. Disease categories include 14 with dementia, five with congestive heart failure, three with multiple sclerosis and six with diabetes. Three participants are in permanent placements in an assisted living or long term care facility, and the program has had one death.

Terence McCormally, MD is the medical director of the program. He is Board Certified in Geriatrics, in practice in Virginia for over 25 years, and was named one of *Washingtonian Magazine's* Top Doctors in 2012.

The average number of clinic visits per member per week is 3.5 days, which is above the projected 2.5 days. The goal of the PACE program is to keep people in the community, rather than the more costly institutionalized care.

For members with an acute need, such as a stroke, skilled nursing and rehabilitative care are provided in a permanent placement (e.g., a nursing home or assisted living facility). Members cannot be dis-enrolled from the program. Despite the permanent placement, InovaCares for Seniors PACE is ultimately responsible for the members' outcomes. About 5-6% of PACE program members nationwide have permanent placements.

The total capacity for InovaCares for Seniors PACE is 120 members. Membership is half of what was projected: Sixty members were expected to enroll during the first year.

InovaCares for Seniors is the 87th PACE program to open in the United States and the first in Northern Virginia. The program has been featured in the *Washington Post* and the *Fairfax County Times*. A total of 3,736 participant van trips have been made between May-December. The program has hosted 28 participant outings and made 54 presentations to the community.

Mr. Hager stated that one of the challenges to enrollment has been the third party approval process. While enrollment increased from 7 to 20 between September and December 2012, the program only enrolled 5-6 members between January-March and one in April.

Mr. Hager said that Inova is working with DFS staff to let them know that PACE may be an option for people trying to avoid institutionalized care. Mr. Hager cited turnover in DFS staff as one reason why enrollment has lagged. Additionally, PACE presents a new administrative change for county staff.

Similarly, Mr. Hager said that they are adapting marketing materials and recruitment tactics to let people know that PACE is a health plan and that they are not required to give up their doctor. Another benefit of PACE is that vision and dental care are provided. Getting individuals to explore the possibility of PACE is the focus of the InovaCares for Seniors' staff.

The program has participants who were born in the U.S., Korea, Vietnam, Liberia, Pakistan, Cambodia, China and Somalia. Resident rights are in multiple languages and translation services are available.

During CMS' site visit, auditors interviewed PACE staff and participants, went on van rides, attended home health appointments, and visited assisted living facilities. CMS expressed concern about InovaCares for Seniors enrollment numbers, but overall, was pleased with the program's outcomes. InovaCares for Seniors is one of the few PACE programs to conclude a site visit without a formal recommendation.

Because InovaCares for Seniors has not met its projected enrollment, the program is losing, on average, \$200,000 a month. Inova had projected to show a profit after 26 months. Likewise, the program was projected to be at full capacity by year two. Most PACE programs do not demonstrate a profit until the end of year three.

The InovaCares for Seniors program is open to dual-eligibles. Five Medicare-only participants are enrolled; they pay the Medicaid subsidy out-of-pocket. PACE is also an option for married couples requiring different levels of medical care, including assisted living.

Mr. Hager acknowledged that Inova has a lot of education to do. However, he is encouraged that the program will increase its enrollment. One of the outcomes of the CMS audit is that Inova can now expand its catchment area to include all zip codes.

Inova provides transportation to and from the program and operates four vans. Pickups and drop-offs are organized by clusters in order to minimize participants' time inside the van. However, transportation remains a significant cost challenge.

Twelve individuals who were part of the Braddock Glen ADHC attend ADHC at PACE. As part of Inova's agreement with the County, Inova provides transportation to those 12 individuals.

PACE participants are not required to remain in the program for a contracted period. They can dis-enroll at any time. The program has had one involuntary dis-enrollment, because the participant has not been willing to move to the first level of the home.

FY 2014 Advertised Budget

Rosalyn Foroobar and Chris Stevens provided an update on the FY 2014 County Budget. Prior to the Board of Supervisors' adoption of the budget, the Health Department was in the process of reorganizing its Environmental Health and Maternal and Child Health programs.

Ms. Blum informed the HCAB that the County Executive's Advertised Budget included a two percent tax rate increase. However, the BOS adopted a one percent increase. As a result, the BOS has eliminated \$1 million in the Department of Fire and Rescue's budget for vehicle replacement (e.g. ambulances and large apparatus requirements). The BOS will revisit this reduction at Carry Over. Additionally, the BOS set aside \$8 million for reductions related to sequestration.

Chris Stevens stated that the BOS' adopted budget includes an eight percent cut to the Community Health Care Network's (CHCN) contract partner, Molina Healthcare. In eliminating funding, the BOS has instructed the Health Department to report back on any adverse impact on services or clients. The BOS did provide the Health Department with some flexibility in how it implements reductions. Four items are included as part of the \$727,000 in CHCN cuts.

Onsite radiology, which amounts to \$245,000, will be eliminated. CHCN performs x-rays that its primary care physicians request in addition to chest films for the Mount Vernon and Herndon-Reston District Offices. The elimination of onsite radiology will also affect Inova's podiatry residents, who run a podiatry clinic at CHCN, and the CHCN orthopedist. Ms. Stevens is working with Michelle Milgrim, Director of Patient Care Services, to explore the possibility of deploying an HD X-ray tech to CHCN for a few hours.

In addition to onsite radiology, specialty care will be reduced an additional \$100,000 from the advertised \$150,000 to \$250,000. CHCN will continue to cover specialty care for oncology and hematology services until the contract expires, around 2015. However, all paid specialty care will be phased out. CHCN makes about 12,000 referrals for specialty care.

After eliminating \$250,000 from CHCN's specialty care, \$50,000-\$75,000 remains and is earmarked for the department's hematology and oncology contracts. Once those contracts expire, patients will most likely go to the University of Virginia (UVA), the National Institutes of Health (NIH), or Johns Hopkins.

CHCN has three telemedicine units, and the medical staff is exploring this option as a way for patients to avoid going to UVA. Ms. Stevens is hopeful that CHCN will be able to work with Inova to provide a specialty care residency program at its facilities. Ms. Stevens said that CHCN will continue to identify any possible resource, including the Medical Society of Northern Virginia's Project Access as well as a shared pro bono network among the region's safety net providers.

To preserve the pharmacy and lab technicians and maintain the clinic's office managers, the program will now eliminate either one physician and/or nurse practitioner position. Two physicians resigned in May so the Health Department will most likely not fill those positions, saving \$219,000.

After eliminating \$245,000 for onsite radiology, \$250,000 for specialty care, and \$219,000 for two physicians, a balance of \$38,000 remains. Ms. Stevens said that this amount will come from eliminating overtime and miscellaneous cost reductions (e.g., technology enhancements, shared physical resources, improved processes, solicitation/recruitment of volunteers).

Ms. Stevens felt that there were no additional efficiencies to be gained from cutting pharmacy expenses. The pharmacy technicians apply and receive \$10.5 million in free medications annually through the pharmaceutical companies' assistance programs. This has saved CHCN's a substantial amount of money in in-house prescriptions. The cost to fill out-of-house scripts cost CHCN \$15,000 a year. Ms. Stevens acknowledged that the availability of PAP prescriptions could change in light of health care reform. She indicated that CHCN would not be able to sustain its current prescriptions without PAP medicines.

Ms. Stevens discussed some ways to track program and client impacts. With respect to in-house radiology, CHCN staff will track the number of films ordered by CHCN providers and in-house specialists, including those for TB patients, and compare it with the number of patients who were able to go and get their films taken at another location. Ms. Blum stated that the difference between where the films are being done

does not tell the impact of the cut. Ms. Stevens agreed and said that they will look at the delay that outsourcing films may cause in diagnosing and treating patients at CHCN.

Likewise, CHCN staff will collect data on the number of treatment plans that did not get filled because patients delayed or could not access specialty care. Ann Zuvekas recommended that staff collect data on patient experience, such as how they made the trip, who took them, how many times they had to return, etc. Additionally, the increase in specialty care referrals to UVA will be tracked. Ms. Stevens said that CHCN staff does have baseline data that will allow them to make comparisons once the cuts are implemented.

CHCN will also collect data on the number of people who are added to the waiting list and the time between putting their name on the list and making their first enrollment appointment. Patients from certain populations, such as maternity, homeless, and mental health, will not be put on a waiting list and will be enrolled for immediate services.

One physician FTE sees 3,600 patients annually. Recruiting physician volunteers is most successful when physicians recruit each other. CHCN will continue to measure the productivity changes from reducing physician coverage.

Ms. Blum recommended that Ms. Stevens or Health Department staff report on a regular basis to the HCAB so that the board can notify the BOS on service impacts. Ms. Foroobar agreed.

Other Business

Marlene Blum and Bill Finerfrock met with Leslie Johnson, the Department of Planning and Zoning's (DPZ) Zoning Administrator. Revising the definition of a medical care facility is a long and arduous process and any changes that are made may become obsolete given how quickly health care delivery and services are changing. Ms. Johnson is going to work with staff to educate them on the Certificate of Need process (CON) and agreed to copy Health Department staff on all medical care facility use determinations. Ms. Johnson is going to work behind the scenes to respond to some of the HCAB's concerns and agreed to attend an upcoming HCAB meeting in the fall.

With respect to the Sunrise Facility of Fair Oak's decision not to accept additional Auxiliary Grant (AG) patients, Ms. Johnson stated that a development condition is tied to the property that is developed, not the business or owner. Sunrise can end its agreement to provide 4% of its beds to low income patients, but it must amend its special exception, which requires staff review, recommendation, and hearings before the HCAB, Planning Commission and Board of Supervisors. Sherryn Craig has left three voice mails for Paul Kelly, the head of Sunrise's Northern Virginia operations. Mr. Kelley has not returned these calls. The HCAB recommended that Ms. Craig notify Ms.

Johnson to begin the formal process of notifying Sunrise of Fair Oak's of its binding development conditions with the County.

As part of the County Executive's advertised budget, a study is underway to look at ways to restructure and consolidate the county's long term care services. The study is reviewing the internal structure of current services and how to minimize duplication and maximize efficiencies (e.g. collocating senior centers at the same facility, sharing food preparation, etc.). Bob Eiffert will attend the June HCAB meeting to seek input and advice on what the community's long term care needs are.

Ms. Foroobar also reported on the Health Department's role in promoting the state's Safe Haven law. Virginia statute permits parents, guardians, or other persons legally responsible for care to surrender an unwanted infant (14 days old or younger) to a designated safe haven – an emergency rescue squad or hospital – without fear of prosecution.

Fairfax County has 37 fire and rescue stations, all of which are safe havens. To comply with state law, Fairfax County EMS issued Standing Order 2003-025, which details the procedures EMS personnel must follow in the event that an infant is surrendered. During the past 10 years that Standing Order 2003-025 has been in effect, no infant has been surrendered to a Fairfax County EMS Station.

Michael Forehand, Inova Advocacy Coordinator, said that in his research, no infant has been surrendered to any of Inova's facilities.

The Health Department will work with Tim Jaccard of the National Safe Haven Alliance, headquartered in Falls Church, Virginia, to identify ways the health department can inform clients of Virginia's Safe Haven law.

There being no further business, the meeting adjourned at 9:43 pm.