HEALTH CARE ADVISORY BOARD

Meeting Summary
February 9, 2015

MEMBERS PRESENT
Marlene Blum, Chairman
Bill Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
Dave West
Ann Zuvekas
Tim Yarboro, MD
Ellyn Crawford
Rosanne Rodilosso
Dr. Michael Trahos, DO
Francine Jupiter

STAFF
Sherryn Craig

MEMBERS ABSENT
None

GUESTS
Gloria Addo-Ayensu, MD, MPH, Health Department
Rosalyn Foroobar, Health Department
Michelle Milgrim, Health Department
Joanna Hemmat, Health Department
Jennifer Ferraro, Health Department
Michael Forehand, Inova Health System
Karen Berube, Inova Health System
Stephen Clement, MD, Inova Health System
John Paul Verderese, MD, Inova Health System
Sharon Arndt, Health Department
Patricia Garcia, Health Department
Sharon Lynn, Department of Family Services
Arsenio DeGuzman, Health Department

Call to Order
The meeting was called to order by Marlene Blum at 7:31 p.m.

Public Hearing on SE-2014-DR-068 Deferred
At the request of Sunrise Development, Inc., the public hearing on SE-2014-DR-068 was deferred until Monday, April 13, 2015.

January Meeting Summary
The January 12, 2015 minutes were accepted as corrected.

Inova Health System
Inova Health System announced its selection of the ExxonMobil Fairfax Campus for the Inova Center for Personalized Health. The Inova Translational Medicine Institute (ITMI) and the Inova Comprehensive Cancer and Research Institute (ICCRI) will anchor the new site. Sherryn Craig will check with the Department of Planning and Zoning to find out if Inova would need to seek an amendment to its original Special Exception application, which would require HCAB review.

HCAB Special Exception Criteria
A suggestion was made to review the supplemental questions submitted to Agape Adult Day Health Care Center (AADHCC) during the HCAB's Special Exception review and recommendation process. It was also suggested that the County Attorney provide guidance on how readily the HCAB's SE Review Criteria can be changed.

Immunization Update
Joanna Hemmat, Assistant Director, Patient Care Services, and Michelle Milgrim, Director, Patient Care Services, briefed the HCAB on local immunization trends. Immunization services at the Health Department fall under the management of the Maternal and Child Health Program and are aligned with the State Health Commissioner and the Virginia Department of Health (VDH) priorities. Services include activities related to the administration and management of vaccines provided by the Health Department (HD), community assessment of immunization status, and outreach and promotional efforts focused on reducing barriers and improving immunization rates.

The HD is a Virginia Vaccines for Children (VVFC) provider, which is a federally funded program providing free vaccines to children who may have difficulty accessing vaccines. By law, any child under the age of 19 may receive free vaccines required for school entry at the HD. As of July 1, the Health Department is required to submit for reimbursement to Medicaid for vaccine administration. The HD provided 30,590 vaccines to 9,115 children in FY 2014, an increase over FY 2013 (27,849 vaccines, 8,788 children). Children's immunizations remain steady, with the exception of FY 2010 and H1N1.

At this time, there are no reported measles cases in Virginia. Fairfax County-level data report measles antigen (MMR) coverage at 82.3% for the two-year-old population, which is slightly below the state rate of 86.4%. School Health Nurses are currently identifying all Fairfax County Public Schools (FCPS) students that are not immunized against measles so if there is a case in a school, the HD can quickly take action.

Marlene Blum informed the HCAB of a recent statement by the advocacy group, Autism Speaks, which encourages parents to vaccinate their children.

Measles is highly communicable and requires an immunity coverage rate between 92-94%. The County coverage rate of 82.3% is below the immunity threshold and the

Health Department is continuing to engage the community through its Community Immunity campaign.

State-level data shows that 81.5% of Virginia's kindergartners have received the recommended vaccines upon school entry. Virginia has medical and religious exemptions to immunization. In Fairfax, less than 1% of children have an exemption.

Through VDH coordination, the HD conducts a retrospective survey every year of children in daycare facilities, Head Start programs, kindergartens and 6th grades to measure compliance with school required vaccinations. Immunization histories from enrollees are collected and analyzed to assess their age-appropriate immunization status. Data are sent to VDH from each locality and combined so statewide immunization rates can be calculated for each category, which then are compiled by the CDC for national and state rates. A public health nurse (PHN), whose responsibility it is to conduct the assessment and survey the County, has not had a statistically significant sample, but is working to see if this year's sample size will be large enough from which to extrapolate.

Dr. Gloria stated that a letter is going out to all FCPS schools that describes community immunity and the need for a significant proportion of the community to be vaccinated if immunizations are to be effective. In the event of an outbreak, children who are not immunized are required to stay home for 21 days.

The HCAB noted that public health officials need to listen to the things being said in the community and explain why vaccinating children is important. The current generation of parents was not exposed to most vaccine preventable diseases like previous generations.

Another suggestion was made to map out those schools where there are high and low percentages of immunized children in order to target campaign efforts. In the case of measles, the exposure window is two hours, so Dr. Gloria felt that prevention efforts were a community issue, not just a particular school.

Many vaccines are completed as a series and while children are working through them, the registrars assess and assume compliance.

In addition to community immunity, the HD is encouraging the use of Virginia's immunization registry, a web-based system where providers can document all the vaccinations a person has received. This registry is a one stop shop that houses a person's immunization records. The registry also includes a recall and reminder system.

During discussion, it was noted that many providers are not aware of the registry. HCAB members suggested that the HD convey this lack of communication to VDH, the State Board of Health, and Board of Medicine.

Inova Center for Healthy Living

The Inova Center for Healthy Living opened one year ago and houses multiple programs at one lcoation, including Inova Transitional Services, Inova Center for Wellness and Metabolic Health, Lab Corps, Pharmacy, and Behavioral Health, which will be moving soon to the Willows Road location along with the County's behavioral health services.

Advances in medicine are allowing patients to live longer and live with multiple co-morbidities. Patients are burdened with these complexities in terms of medication management, coordinating their own care and are increasingly expected to do this on their own while still sick and without much training. Financial constraints loom with penalties arising from payers in order to contain costs and pressures to move people out of acute care settings quicker. Private practitioners are not always equipped to effectively handle their patients solo, especially those who are recovering from an acute illness. Many patients for various reasons simply do not have access to a physician who can help them.

These drivers create a revolving door where patients cycle in and out of emergency rooms. Dr. Verderese, Medical Director, Transitional Services and Home Health, characterized these forces as inefficient, costly, unsafe, unsatisfying, and unsustainable.

These gaps begin upon discharge. Are patients going to follow up with someone? Do patients know about their conditions and how to self manage them? Do patients know why, when and how to take their medications? Do patients have a primary care physician or medical home.

Many patients have no access to any physician post-discharge, and some patients are complex and require very close and frequent follow up under the supervision of clinicians that are adept at caring for those with decompensated illnesses. Patients also have other illness outside of the TCM diagnoses that need similar support. Simply stated, patients need extra help after they leave the hospital to make sure they transition home and back to health safely.

The Inova Transitional Services (ITS) Transitional Care Management (TCM) Program began in 2011. Health Coaches and Case Managers help patients navigate their care post-discharge using a 30-day telephonic health coaching program for patients with high risk diagnoses (e.g., Chronic Obstructive Pulmonary Disease [COPD], Congestive Heart Failure [CHD], Diabetes, and Asthma) who were treated in the hospital and/or emergency room (ER). Fairfax and Alexandria are TCM's largest referral source. Roughly 70% of referrals are from the hospital; 30% are from the ER.

TCM clients are uninsured, have plain Medicare and/or Medicaid, or Aetna Innovation Health. While a fair number are over 65 years of age, the majority of TCM clients are under 65-years and/or uninsured.

TCM clients are referred to a provider that's conveniently located to them, and in some cases, that's an Inova Medical Group (IMG) physician. In 2014, there were 2,000 unique TCM patients with 10,000 scheduled visits.

TCM offers added telephonic case management services, Home Health facilitation, 7-day follow up, and placement or help coordinating other applicable community services. The program does take advantage of Medicare's reimbursement for transitional care management services.

An ITS Clinic was started in 2013 with three sites (e.g., Fairfax, Herndon, and Leesburg). Staff include a Medical Director, MDs, Nurse Practitioners, Social Workers, Chronic Care Registered Nurses (RNs), and a Pharmacist. There is also podiatry and psychiatry support.

ITS goals include: reduced hospital admissions, improved patient satisfaction, improved provider satisfaction, reduced ED and hospital length of stays (LOS), decreased adverse post-hospitalization events, reduced ED utilization, and improved cost/benefits of care

By combining programs at one site, formerly separate entities are now integrated. Inova is also helping the community safety net clinics by handing off stable patients who are willing to participate. The program also coordinates getting medications (via Pharmacy Assistance) for hundreds of people. ITS' cooperation with Inova Home Health helps care for homebound patients who otherwise would not have a physician. Lastly, the Center provides training programs for residents and students. Karen Berube said that Inova is currently looking for space in Alexandria for the former Inova Mount Vernon Hospital's Diabetes Center.

Dr. Clement, Medical Director, Endocrinology Services, Inova Center for Wellness and Metabolic Health, stated that an epidemic of pre-diabetes and diabetes is causing most cardiovascular disease events. The human body is not designed and programmed to eat many of the non-nutritious, convenience foods available in the market. If current trends continue, approximately one in three people are going to develop diabetes in their lifetime.

Services provided by the Wellness Center include pre-diabetes and diabetes education and treatment, medically supervised weight loss, and management of metabolic problems in specialized patient groups (i.e., chronic vascular disease, lung patients).

The Center for Wellness and Metabolic Health has received requests from the Inova Heart and Vascular Institute (IHVI) for blocks of 10 to 15 visits per day for its patients.

The focus of the center extends beyond diabetes to include obesity, nutrition and weight management. Inova hopes to grow the clinic over the next several years.

Prior to redesigning the model for the center, the program was strictly educational, providing four sessions for four hours for up to eight people per group. The program could not accommodate many patients using this framework, and there was a 26% no-show rate: most patients would come for the first session, a third for the second, and almost no one attended the third or fourth sessions. Despite the lack attendance, these sessions were still blocked on providers' calendars. On average, about four to five thousand visits occurred under the old framework, which is not many given the current diabetes epidemic.

The Center's challenge moving forward is to meet the demand that currently exists in the community. The new model will allow for more individualized care planning. In addition to diabetes, the Center will be able to treat pre-diabetes and gestational diabetes as well. On average, IFH sees around seven pediatric patients a month. Ms. Berube will keep the HCAB informed about overall utilization, but the Center's current demographics mirror most of TCM's.

Like TCM, the Wellness Center is leveraging Medicare reimbursement dollars for self-education management and medical nutrition therapy.

HCAB members who are interested in visiting Inova's Center for Healthy Living should contact Mike Forehand.

Chronic Disease Self Management Program (CDSMP)

The Chronic Disease Self Management Program (CDSMP) is a community-based support program for chronic disease. The CDSMP emphasizes the patients' role in managing their illness and building their self-confidence so they can be successful in adopting healthy behaviors.

CDSMP was developed by Stanford University in 1996 by Kate Lorig and colleagues. The program is evidence-based and has been successfully implemented by health services and organizations worldwide. CDSMP can be adapted for various cultural groups, as well as for specific chronic conditions. The CDSMP consists of six weekly sessions, each lasting 2-3 hours, 10-16 participants per group.

Subjects covered include:

- Accepted techniques for dealing with problems such as frustration, fatigue, pain and isolation,
- Appropriate exercise for maintaining and improving strength, flexibility, and endurance,
- Appropriate use of medications,
- Effective means of communicating with family, friends, and health professionals,

- Good nutrition, and
- Means of evaluating new treatments.

The CDSMP program workshops are facilitated by community health workers who have been trained and certified as CDSMP curriculum leaders by CDSMP Master Trainer level Community Health Workers. Master trainers are members of the community who deliver programming to their peers. Examples include how to read labels to practice good nutrition, be on target with medication, and speaking in a different manner with your doctor. Master trainers cultivate self empowerment and small steps that individuals can take to control their health.

The Fairfax Area Agency on Aging (FAAA) through Elderlink provides direction and coordination for the implementation of CDSMP throughout the Fairfax Community. CDSMP is supported by a grant from the state Department of Aging and Rehabilitative Services (DARS) as You Can! Live Well, Virginia!, that holds the Stanford license used within by the community.

Fidelity reporting on existing CDSMP has been the purview of FAAA. In the program 2013 grant year, there were 258 completers (i.e., participants completed four out of six classes). Since the program began in 2011, there have been almost 1,500 participants, 800 completers, 33 workshops (7 on diabetes and 23 Spanish-focused). The state reimburses the program for a certain number of completers. The Fairfax CDSMP continues to have completers in excess of its program targets.

The FAAA is currently in the last year of its grant, and each year, program funding has been cut. Train the trainer sessions cost $1,700 per master trainer, $900 per layperson. Laypeople (e.g., nonmedical providers) become the most effective leaders, as they are able to speak to their peers about how they're accomplishing their goals and providing mutual encouragement.

The FAAA provides the curriculum and all materials for CDSMP workshops. The Health Department Outreach staff deliver CDSMP Workshops in accordance with the MOA between the Department of Family Services and Health Department, signed 2/15/2013. This agreement is currently under review for amendment.

The Partnership for a Healthier Fairfax (PFHF) Health Workforce Team identified CDSMP as a Community Health Improvement Plan (CHIP) priority to reach more minorities in medically underserved communities. The PFHF Health Workforce Team developed a sustainability model for CDSMP expansion within the community. HD and DFS have collaborated on identifying target populations most suitable for interagency program coordination efforts.

Community Transformation Grant funds were used to purchase a second license to expand CDSMP capacity within the Fairfax community. The HD license is effective for

three years (September 2014 – September 2017) and allows for 65 workshops and 4 leader trainings. The CDSMP model implementation was a component of the Health Department's unsuccessful Partnerships to Improve Community Health (PICH) grant application.

While FAAA's focus for CDSMP is older adults, the HD's is slightly different. The license will be shared with volunteer partners in medically underserved and ethnically diverse communities. CDSMP provides benefits to the HD as a valuable outreach and community engagement mechanism. It provides a way in the front door in order to build relationships around health and engage in other outreach efforts. CDSMP is not a population-based initiative; there are a lot of resources that go into this program.

CDSMP is a strong adjunct to the educational programs offered by the hospital system for diabetes and chronic disease.

FAAA does not have a grant ready for next year, but feels it can keep the program growing. The program employs a half-time coordinator through Adult and Aging Services, Colleen Turner, and the only other costs are the books and snacks/food. The HD's program is not fully off the ground yet.

The FAAA has not reached out to any assisted living and/or continuing care communities as its target population are individuals still living in the community. The HCAB recommended these populations since they may have the ability to pay for CDSMP services. Those recovered revenues could then be used to provide resources to populations that cannot pay for CDSMP.

The CDSMP does receive referrals from Inova. CDSMP has a staff person that is being paid directly by Inova and is taking referrals from the Inova Transitional Care Program and its case managers. The referral process is done by e-mail.

Continuing education does occur. The CDSMP curriculum is updated periodically and trainings and new books do follow. The FAAA is starting a new curriculum for cancer and chronic pain.

The DFS and HD agreed to keep the HCAB updated on the program's progress, including any budgetary challenges. Sherryn Craig will distribute FAAA's CDSMP factsheet electronically.

RFP for Primary Care and Pharmacy Services

The existing contract with Molina healthcare was supposed to run through June 2016, but for various reasons, the decision has been made to terminate the contract December 2015. The County and Molina will be involved in a lot of transition during the next nine to 12 months. The County has received assurances from Molina that it can

be available for two to three months after December 2015 to finalize the transition to another provider.

To address the existing and ongoing needs of the safety net population and build upon the work already done towards formalizing an integrated health care delivery system, the County is currently engaged in the development of a new RFP that will:

- Update how the County provides primary care through the CHCN.
- Promote health care services access to all people served through the CSB in need of primary care – and those served through CHCN in need of behavioral health. All primary care sites will develop a capacity for behavioral health services with consideration for highly specialized behavioral health services provided at the Merrifield Center (allowing for additional access to crisis observation and emergency services, if required). The CHCN and CSB sites would function as one network for the uninsured and Medicaid (or otherwise insured) patients from CSB, with the County deciding which level of service to offer at each site.
- Encourage leveraging of all available eligibility/enrollment and health services (i.e., primary care, behavioral health, dental services, specialty care, and pharmacy) resources into a better integrated (not just co-located) service delivery system. The successful bidder to operate County primary care and pharmacy services would have to demonstrate the ability to manage complex CHCN and CSB patients with medical conditions and reach an agreement to assure that the same number of uninsured patients would be cared for at the CHCN. The vendor would also be ready to change the focus of these clinics as changes occur in Medicaid coverage.

The new RFP will redefine the target population for CHCN to include those for whom access and coordination of care has been a significant problem – the uninsured and those covered by Medicaid, particularly those Medicaid enrollees with significant medical and behavioral health problems that require comprehensive coordination of care to assure both positive health outcomes and minimize over-expenditure of resources. While CHCN will accept other payer sources, including Medicare and Medicaid, the uninsured will be prioritized.

With respect to timeframe, the RFP is written and has gone to Purchasing and Supply Management for review and release. Ideally, a pre-proposal conference would be scheduled for early spring with submission to occur late spring. Review, award and negotiation would be anticipated for fall.

The County would maintain control of eligibility determination while continuing to meet the highest quality standards. With the County accepting other forms of insurance, there may be competitive pressure placed on the region's FQHCs, which is why they

have been actively involved in the planning process. It is paramount that all safety net providers maintain their viability and sustainability.

The new vendor will be expected to provide information technology (IT) resources/electronic medical record (EMR).

There being no further business, the meeting adjourned at 10:01 pm.