

HEALTH CARE ADVISORY BOARD

Meeting Summary February 10, 2003

MEMBERS PRESENT

Marlene Blum, Chairman
Rose Chu, Vice Chairman
Bill Finerfrock, Vice Chairman
John Clark
Pamela Herbert
J. Martin Lebowitz
Susan Randall
Rosanne Rodilosso
David West
Timothy Yarboro

GUESTS

JoAnne Jorgenson - Health Department
Carol Sharrett - Health Department
Michelle Bachus – Health Department
Chris Stevens – Health Department
Gloria Addo-Ayensu – Health Department
Ann Zuvekas – Community Advisory Cmte.

STAFF

John Ruthinoski

The meeting was called to order at 7:35 p.m.

Approval of the Minutes

The minutes of the January 13, 2003 HCAB meeting were accepted as submitted.

Marlene Blum reminded HCAB members that the agenda had been changed to ensure that the Community Advisory Committee report would be the first item.

Community Advisory Committee Report

Rose Chu began by reporting that last year, the Community Advisory Committee (CAC) thought that it would be a good idea to take a comprehensive look at the Community Health Care Network (CHCN). There is a long waiting list at each of the three centers with over 3,000 waiting for enrollment into the program. In addition, the number of visits per person was not as high as industry standards. She added that the reason for this is that the program's population was linguistically challenged, requiring longer visits. Fewer than 26% of the program's clients speak English. She added that drug costs have risen, but that the cost per client has increased at a rate slower than Medical CPI. To offset costs, the program has introduced a closed formulary and is utilizing drug companies' charity programs, but these measures have had only limited effectiveness.

Rose Chu reported that to begin its work, the CAC adopted the Institute of Medicine's definition of Primary Care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Ann Zuvekas noted that the HCAB has already been briefed on the changes made by the CHCN last year to reduce costs. She added that the CAC is looking at changes that could be made to best serve the patients who were already enrolled in the program. She added that the staff at the health centers provide more than would be available at a regular family practice, including the linguistic capabilities of staff, medical social worker, and onsite pharmacy and x-ray services. She added that the program provides \$4.5 M in specialist services per year, \$3.0 M of it pro bono. The patients who access these services are sicker, and less likely to speak English than other CHCN clients. She added that there is no hard evidence, but plenty of anecdotal evidence to suggest that a significant number of patients are "imported" into the County for enrollment to the CHCN. These patients come from other areas of Virginia and other states as well as other countries.

Ann Zuvekas noted that she participated in the original study which resulted in the creation of the CHCN. She explained that at the time, it was believed that there would certainly be some kind of expansion of medical care in the next few years. Much has changed in the intervening years. For example, pharmacy services were not considered that essential in 1987. In the ensuing years, there has been an explosion of the uninsured (there are now 41 million nationwide) and a contraction of benefits. The federal government is backing away from services to poor people and the states are not "stepping up to the plate". Therefore, the County is left trying to solve a national issue with only general fund dollars at a time of taxpayer revolt. Therefore, it was clear that expanding the program to meet increasing demand was not an option.

The CAC drew up a list of questions that it would like answered, including:

- What does the program look like?
- Who does it serve and not serve?
- Who is on the waiting list?
- How sick are they?
- How do you determine access?

After they had determined the questions, the CAC looked at data sources for the answers, including demographics for both the County and the Health Centers. They also looked at how other community health centers across the country are dealing with similar problems. Finally, a number of projects were carried out at the health centers, including a patient flow analysis, time/motion studies, focus groups and interviews with clients and staff. The next step was the development of criteria for evaluating potential strategies. Following some brainstorming sessions, a total of six strategies were developed. These were:

- A. Continue to provide full primary care to the same number of patients
- B. Provide basic care to more patients

- C. Complete analyses of cost efficiencies (such as chart review, etc.)
- D. Develop community-wide partnerships
- E. Offer training and education to staff and patients (including patient education and culturally competency for providers)
- F. Seek and access other resources (such as becoming a federally qualified health center, or looking for other foundation or private grants)

When the strategies were evaluated, it was decided that strategies C-F should all be pursued. Strategies A and B, however are mutually exclusive and embody different sets of values.

John Clark then discussed how the CAC evaluated the strategies. While strategy B would contain costs, there was a fear among health center staff that it could result poorer clinical care. Strategy A would serve fewer patients, but would provide them all with adequate care. Marlene Blum directed the HCAB's attention to the matrix evaluating the strategies. A comparison of the strategies' cost per patient reveals that employing strategy B does not result in a huge increase in the number of patients served.

Dr. Lebowitz commented that the report was well written and self-explanatory. He stated that it clearly demonstrated the program's current dilemma. He added that he has always felt concerned regarding the number of people who are "frozen out" of the program. However, he noted that the program could not have come to any other conclusion. If they tried providing only "basic coverage," not only is it hard to define, but it puts practitioners in the position of providing substandard care. He also noted that from now on, the program is going to have to be very rigid about enrollment requirements. For example, clients will have to be moved out promptly once they turn 65. He added that if the program's goal is to provide full primary care, then he sees a contradiction in choosing strategy A, but only allowing one specialty visit per annum.

Chris Stevens noted that the limitation in specialty care was a very difficult decision, but added that the specialists essentially made it themselves. She also noted that the limitation was one visit to the CHCN's specialty network per year. Other types of referrals, such as to UVA, would still be available to patients. Dr. Lebowitz responded that while it is a good idea to limit specialty referrals, it is another thing entirely to cap referrals at an arbitrary number. Marlene Blum commented that the report needed to reflect the fact that the program allows for appropriate exceptions to the one referral per year policy. Dr. Lebowitz added that if the program is going to continue with strategy A, it is going to have to re-examine its provider network.

Bill Finerfrock asked if Strategy F included the option of becoming a Community Health Center (CHC). JoAnne Jorgenson responded that Arlington, Alexandria and Fairfax had been approved as a Minority Underserved Population (MUP). She added that the Arlandria clinic is applying to be a CHC, and that the CHCN centers could be satellites

of that CHC. She added that there still needs to be some interjurisdictional work done on this issue, and that no decision has been made yet as to how to proceed. Bill Finerfrock reminded the Health Department that the satellites do not need to be in the MUP area. He also noted that funding for CHCs has risen in the last two years. He also noted that the Centers would not be able to turn anyone away due to having other sources of care if they were designated as a CHC. Marlene Blum noted that the Health Department could develop a separate entity to be the CHC, separate from the CHCN, which would address this concern. JoAnne Jorgenson noted that Alexandria's MUP designation was based on language and the lack of Medicaid providers. Fairfax (the Bailey's area) was only designated due to language. Therefore, the area may be a quasi-MUP. Bill Finerfrock added that he was glad that this is an option for the Health Department.

Dr. Herbert noted that there was not a tremendous difference between strategies A and B. She added that she did not see the greater good that Strategy A is doing over strategy B, given that strategy A only allows one specialty visit per year. Chris Stevens reiterated that the program provides more than one specialty visit per year now. In fact, since instituting the policy six months ago, only 58 out of 17,000 referrals were sent to UVA. She added that the policy was put in place to placate the specialists who only receive 50% of what Medicaid pays them for a visit. Some used to provide services pro bono, but many do not any more. Many are dropping out, because the cost of malpractice insurance is prohibitive.

JoAnne Jorgenson noted that in Strategy A, the CHCN is essentially capping enrollment, providing the best possible comprehensive care, and trying to maximize care provided for clients. If this means trying to get more funding for specialists, the Health Department will have to look into this. However, Strategy B says to the client, "you are on your own for specialty care." Marlene Blum noted that one referral means more than one visit. Dr. Herbert noted that neither strategy seems to allow clients more than one diagnosis. Chris Stevens noted that the CHCN pays for bundled referrals. She added that if the CHCN could get some help in recruiting specialists it could increase the number of referrals.

Dr. Herbert noted that the average cost per referral was only \$78 per patient. Chris Stevens noted that this was average over all clients, not just those needing a referral. Dr. Lebowitz commented that the HCAB may be making too much of the referral issue. He asked Dr. Yarboro, who operates a family practice, how many of his patients need referrals. Dr. Yarboro stated that less than 50% needed a referral, and most of the time they only needed one visit. Bill Finerfrock noted that the CHCN's population is much sicker than Dr. Yarboro's. Dr. Lebowitz noted that if someone is going to have a stroke, they are not going to do it in a doctor's office. Therefore, the most expensive costs (emergency care and hospitalization) are not going to be borne by the program.

Marlene Blum suggested that the HCAB support the report and recommended sending it to the Board of Supervisors and the County Executive, stating that the HCAB heard a presentation from the CAC. Rose Chu made this a motion and Dr. Lebowitz seconded. JoAnne Jorgenson suggested sending it to the Human Services Council. Susan Randall added that Inova should get a copy and Dr. Lebowitz suggested that Medical Society as well. JoAnne Jorgenson thanked the committee for its work. She noted that it was a very painful process, but it was worthwhile. She added that the County Executive was very pleased that the Health Department went "out of the box" to examine this problem. Marlene Blum noted that the physicians and nurses in the health centers did much of the work for this report and they are to be thanked. JoAnne and Marlene also both thanked Ann Zuvekas for her efforts.

Emergency Preparedness Plan Update

Michelle Bachus began by noting that she would be providing an update of the Health Department's pre-event and post-event smallpox vaccination preparations. Pre-event activities began in December, when the President initiated the pre-event vaccine program for public health response teams and first responders. Post-event plans would only go into effect if a case of smallpox is identified. The County has identified its response team, made up of public health nurses and environmental health specialists who have volunteered. They have been informed of the many contraindications for the vaccine for themselves and any household contacts. The vaccine has already arrived in Richmond, and hopefully the Health Department's team will start being vaccinated in a few weeks. Hospitals in the County are in the process of identifying their teams now and once the Health Department's team is identified, it will vaccinate the hospitals' teams.

Marlene Blum reported that the Volunteer Fairfax has started to recruit volunteers to assist in post-event vaccinations. Michelle Bachus reported that Volunteer Fairfax would be managing the volunteer database for the County's post-event planning. Bill Finerfrock asked where the County was getting its information on responding to possible radiological events. Michelle Bachus responded that they get most of their information from the State. Bill Finerfrock offered other sources of information on this type of event. Bill Finerfrock asked if smallpox was weaponizable like anthrax. Michelle Bachus responded that it was, and that unlike anthrax, it could also be spread person-to-person. Bill Finerfrock asked how long the incubation period was for smallpox. Michelle Bachus responded that it could take 2 weeks for symptoms to appear. Dr. Sharrett added that the person would not be infectious for all 2 weeks. They would only be infectious for about 24 hrs. before they started showing symptoms. However, once they start showing symptoms, they would be very ill, and likely not be out in public.

Michelle Bachus explained the use of the incident command system that the Health Department has put into place for post-event response and also explained the purpose of the Bioterrorism Medical Action Teams (BMATs) which would be needed to help

vaccinate Fairfax County's population in the event of a smallpox outbreak. The County is looking for 5,000 medical volunteers to participate in BMATs. They are working with the George Mason University School of Nursing to obtain volunteers for the BMATs.

Dr. Yarboro asked how people living in nursing homes and other non-mobile persons would be vaccinated. Michelle Bachus responded that the medical staff at the nursing homes would be trained in how to vaccinate their patients. She also noted that the County is working with Fastran to develop a plan for transporting people to the vaccination sites. Bill Finerfrock commented that the potential harm from panic would be worse than the impact of the incident itself. Dr. Lebowitz noted that we have an advantage now that wasn't available in previous epidemics: television. He added that there is considerable skepticism in the medical community about the need to vaccinate response teams. To date, 380 hospitals have declined to have their staff vaccinated. He added that the vaccine causes 2 deaths per million people vaccinated and 58 serious complications. He added that there is no proof that there is any smallpox outside the United States and Russia's stockpiles. He added that he spoke to Dr. Morrison, who indicated that the only reason Inova was having its staff vaccinated was its proximity to Washington.

Dr. Herbert asked if the military had started being vaccinated. Michelle Bachus answered that military personnel were already being vaccinated. Rose Chu asked if there was any federal money being provided for the pre-event planning. JoAnne Jorgenson responded that the federal government was paying for the vaccine and the syringes, but nothing else. Marlene Blum asked about the status of the County's new epidemiologist position. JoAnne Jorgenson responded that the Health Department was currently interviewing candidates for this position.

Rosanne Rodilosso asked what kinds of reactions people were having to the vaccine. Michelle Bachus responded that people experience redness at the vaccine site, swelling, fever, aches and pains. In individuals who have never been vaccinated, 30% of people vaccinated have a reaction. Dr. Gloria Addo-Ayensu reported that some medical conditions predispose people to a negative reaction, such as a weakened immune system (as in people with HIV or people who have received an organ transplant), eczema or atopic dermatitis, burns, severe acne or psoriasis, and pregnancy or breast feeding. In addition, if you have children under one year old, the vaccine is not recommended. All of the contraindications apply to vaccine recipients and household contacts. However, if there is an outbreak of smallpox, the benefits of the vaccine would outweigh the risks. Dr. Herbert asked if there have been negative reactions among the people currently being vaccinated. Dr. Sharrett responded that there have been some adverse reactions.

Zoning Ordinance Amendment

Marlene Blum reminded the HCAB that over a year ago, there had been a proposed amendment to the zoning ordinance which would have been very negative. The HCAB commented on the proposal at the time. The good news is that the HCAB's comments were heard and that the new proposal is excellent. It incorporates a recommendation from the Adult Care Residence Study Group's report requesting that ACRs (now assisted living facilities) be defined in the zoning ordinance and classified as medical care facilities. Marlene Blum proposed that the HCAB send testimony to the Board of Supervisors supporting the changes. John Clark made this a motion and Dr. Herbert seconded. The motion passed unanimously.

Other Business

John Ruthinoski distributed a copy of the County's report on its implementation of the Americans with Disabilities Act.

Marlene Blum announced that the Community Action Advisory Board was commemorating "Cover the Uninsured Week," March 10-16, 2003. She added that she wanted to give the HCAB an opportunity to participate in this event.

John Ruthinoski reported that the HCAB would be meeting March 3, 10th and 24th when reviewing the FY 2004 budget. Marlene Blum reported that the budget would be released on February 24th. She added that the HCAB would most likely not meet in April.

There being no further business, the meeting was adjourned at 9:45 p.m.