

HEALTH CARE ADVISORY BOARD

Meeting Summary
October 10, 2007

MEMBERS PRESENT

Marlene Blum, Chairman
Bill Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
J. Martin Lebowitz
Rosanne Rodillo
John Clark
Dave West
Francine Jupiter
Ellyn Crawford
Tim Yarborough

STAFF

Sherryn Craig

GUESTS

JoAnne Jorgenson, Health Department
Michelle Milgrim, Health Department
Julianna Miner, Health Department
Anne Rieger, Inova Health System

The meeting was called to order at 7:50 pm.

Approval of the Minutes

The minutes of the September 10, 2007 HCAB meeting were accepted as corrected.

Mobilizing for Action through Planning and Partnership (MAPP) and Balanced Scorecard

Julianna Miner, Strategic Planner, provided an update on the Mobilizing for Action through Planning and Partnership (MAPP) and the Balanced Scorecard processes. MAPP is a community-wide assessment strategic planning tool for improving public health. This tool provides a method to help communities prioritize public health issues, identify resources for addressing them, and strategize ways to take action.

MAPP was developed by the National Association for City and County Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Approximately 250 Local Health Departments have completed the process and approximately 500 Local Health Departments have used the process in whole or in part. MAPP is projected to take 3 years to complete and is a community-inclusive process.

MAPP will have benefits for both the County and the Health Department. MAPP will allow the County to: (1) Develop a comprehensive Community Health Assessment that can be used by all human services and health care providers; (2) create a healthy community and a better quality of life; (3) create a stronger health infrastructure; and (4) engage the community and create community ownership for health issues. With respect to the Health Department, MAPP will provide (1) a community-driven long-term strategic plan; (2) increase the visibility of public health within the community, and (3) allow staff to anticipate and manage change.

The Health Department will coordinate the MAPP process. Julie indicated that there would be a multi-disciplinary committee comprised of 20-40 community participants who will develop the vision and conduct the assessments. The core planning team will be comprised of 5-10 health department staff that will do the day-to-day work.

The proposed MAPP timeline includes:

- Kick Off/Orientation meeting (2 hours)
- Assessment 1: Local Public Health System Assessment (1 day retreat)
- Assessment 2: Community Health Assessment (3 months)
- Assessment 3: Community Themes and Strengths Assessment (4 months)
- Assessment 4: Forces of Change Assessment and Identification of Strategic Issues (1 day retreat)
- Development of Goals and Strategies (1/2 day retreat)
- Write up of Comprehensive Community Assessment
- Development of Health Department Balanced Scorecard and Strategic Plan

Julie hoped the HCAB would provide representation on and/or identify potential members for the big community planning group. She also said she would look to the HCAB to provide feedback on the process and progress of MAPP.

Julie asked HCAB members if they had a preference for meetings (e.g. many small meetings or fewer all day/half day meetings). Marlene Blum and Francine Jupiter said that how Julie organizes a meeting depends on what is being done and who is facilitating the meeting. Marlene suggested that at the beginning of the process, she has found it better to have shorter meetings. Based on her understanding of the MAPP process, though, it may be necessary to have meetings that are more than one day. Dr. Lebowitz suggested that unless discussion is abbreviated, some of the assessments would take more than half a day to complete.

Marlene said that the HCAB could be useful on the big community planning group, and that some members might like to be involved in the community assessment and focus groups. Marlene suggested that the membership of the planning group be broad and encouraged Julie to work with the Department of Systems Management to set up the focus groups.

Marlene asked when the Health Department was planning to brief the Board of Supervisors (BOS). There was some discussion of whether staff should wait before or after a new Board was seated. It was decided that staff would wait until after the election to visit the BOS. There was agreement that the Health Department should reach out to Supervisors who are not seeking re-election.

The idea of a health summit was also raised. Francine suggested that once the MAPP was completed, the Health Department could organize a summit.

Dr. Yarborough suggested that staff consider using interactive media to engage younger participants or participants whose schedules do not allow for traditional meetings.

JoAnne encouraged HCAB members to contact Julie with any suggestions or ideas they may have regarding MAPP.

Julie presented an overview of the Balanced Scorecard process. In May 2007, the County mandated that all agencies develop a balanced scorecard. This strategic planning tool will help County leadership coordinate and align the direction of diverse agencies, programs, and functions. Each agency must produce a Strategy Map (i.e. an abbreviated flow chart) by May 2008. Balanced scorecards are due December 2008. The Health Department's scorecard must be aligned with both the County and Human Services' objectives.

Julie presented a framework for completing both MAPP and the Balanced Scorecard processes. She believes that the agency's current approach (e.g. performance measures and budget indicators), described as "bottom up," would feed into these new "top-down" processes. While there is no guarantee that these tools will complement each other perfectly, Julie was convinced that the Health Department could get reasonably close.

Homeless Healthcare Program (HHP) Midyear Report

Michelle Milgrim presented the first six months of data (January 1 – June 30, 2007) from the Homeless Healthcare Program (HHP). Between February and June 2006, the Mobile Medical Services Committee met to design a continuum of physical and behavioral health care services for unsheltered homeless persons whose needs are not being met by the current system of health care services (both public and private). The guiding principle for program development was that the model fit Fairfax County and should be a starting point for a larger effort tied to the Fairfax County's Plan to Prevent and End Homelessness.

Based on these discussions, HHP was created to provide outreach to the unsheltered homeless and connect the unsheltered with existing County services. Four mobile medical teams, comprised of nurse practitioners (medical and psychiatric), outreach workers, and mental/substance abuse outreach workers, in addition to one part-time psychiatrist, are dispatched to areas of the county where the unsheltered homeless live. After assessing each client, teams provide physical and behavioral health care, as well as referral and transportation to medical care, mental health and alcohol and drug services and dental resources. The unsheltered are offered the opportunity to enroll in existing County programs, be they emergency shelters, alcohol and substance abuse treatment, Community Health Care Network (CHCN), and/or mental health counseling. They are also afforded the opportunity to enroll in the dental and/or denture programs created and funded specifically for HHP.

Based on the data from the first two quarters, the average HHP client was a white male between 40-55 years-old and reported that the street was his primary residence. In the third quarter, changes were made to the assessment to minimize the amount of missing data. In addition to Outreach Workers (OWR), NPs are also collecting demographic information. Based on preliminary data from the third quarter, it looks like the HHP population may be more diverse.

OWRs saw 209 unduplicated clients during the 1st Quarter. These clients were evenly distributed across the County, with the Southern part of the County seeing the most. OWRs used face-to-face meetings, telephone calls, and/or third party contact to establish relationships with homeless individuals. The intensity levels of these contacts varied, but it appears the majority of outreach occurred in person. Based on the graphs that Michelle presented, it appeared that the unduplicated client count dropped from 1st to 2nd quarter. However, due to ORWs submitting data by hand during the first quarter, client counts were duplicated.

The places where outreach occurred varied by region, but the majority of clients received outreach services at a drop-in shelter.

During the first six months of the program, OWRs made 833 referrals. The largest referral service category across all providers was transportation. As part of HHP, the nonprofit contractors were given money to purchase a van in order to get clients to and from appointments.

The Mental Health NP provided care to 47 unduplicated clients during the first two quarters. PATH workers also provided substantial assistance with substance abuse and mental health counseling, seeing 575 clients throughout the first half of the year. The Community Services Board (CSB) was able to hire a part-time psychiatrist in the second quarter who treated 10 unduplicated clients. One important caveat to the CSB's outcomes is their database only tracks clients who have accepted medication as part of

their treatment. So it is safe to assume that their numbers understate the true needs of HHP clients.

The Northern Virginia Dental Clinic (NVDC) provided care to 59 unduplicated clients between January and June. A new contract was also signed with Winchester Affordable Dentures, which allowed the program to provide restorative dental care to 6 patients.

NPs provided care to 263 unduplicated clients in the first quarter and 188 in the second quarter. Based on the number of assessments, NPs met with clients more than once before they could connect them with existing medical services. Patients were referred to NPs primarily through Drop In Centers. During the first quarter, Hypothermia Programs provided a number of referrals which tapered off when Hypothermia concluded at the end of March. By the second quarter, warmer weather allowed OWRs and NPs to increase their street outreach, and an increase in referrals followed.

NPs documented patients' medical complaints by system. HHP patients primarily suffered from Head, Eyes, Ears, Nose, and Throat problems as well as Integumentary and Musculoskeletal problems.

NPs referred HHP clients to other sources of medical care, with CHCN as the top referral for both quarters.

Finally, NPs asked patients if they had a regular source of medical care. The majority of patients for both quarters reported that they had no medical home. Attempts to link clients with CHCN proved moderately successful: approximately 1 in 5 clients was enrolled in CHCN.

HHP has had some program challenges during the first six months. NPs are new to street outreach and have had to adapt how they interact with clients. The CSB recently conducted a training for all HHP staff that provided best practices in conducting outreach. Second, OWRs have experienced challenges with collecting and reporting data. Third, HHP staff spend a lot of time engaging clients, and there may be some potential for burn-out.

Dr. Yarborough asked if staff was tracking how long clients had been homeless so that they could analyze the effectiveness of the program. Bill Finerfrock echoed these concerns and suggested that success could be defined in various ways. It was important to collect aggregate data, but it may also be useful to segregate the population to determine different levels of treatment and effect.

Dr. Lebowitz asked how many patients sought follow up care. Medmark is currently looking at that information to find out how many HHP clients returned two or more times to CHCN.

A question was asked about HHP's integration with a Housing First Model. JoAnne Jorgenson stated that the flexibility of the HHP model should allow for such a transition.

Anne Rieger asked if clients were asked why they did not enroll in CHCN. Michelle stated that one of the primary barriers remains transportation.

Bill Finerfrock asked if NPs were tracking patients' diagnoses. A copy of the NP's medical assessment form was distributed to HCAB members. NPs are documenting the priority and severity of patients' diagnoses. By assigning International Classification of Diseases, 9th Edition (ICD-9) codes to each diagnosis, Health Department staff also hopes to generate cost-savings data for the program.

Dr. Lebowitz suggested that staff provide HHP clients with a card or wrist band that indicates they were seen by an NP. This suggestion led to a question about electronic medical records. JoAnne noted that staff was working toward this goal, but that it would take some time to get there.

Marlene Blum asked when staff was planning to present this data to the BOS. JoAnne said a report would be prepared at the end of the first year.

Review of HCAB Work Plan

Due to the late hour, Marlene suggested that HCAB members review the work plan and consider it in context with Julie's presentation. Julie and Sherryn will prepare a sign up sheet for various work assignments, focus groups, and/or assessments. The HCAB will revisit the work plan and MAPP participation at the December meeting.

Other Business

The November 12 HCAB meeting will be held at the Health Department. Sherryn will send out an e-mail noting the location change.

The meeting was adjourned at 9:55 pm.