HEALTH CARE ADVISORY BOARD

Meeting Summary
December 10, 2007

MEMBERS PRESENT
Marlene Blum, Chairman
Bill Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
Rosanne Rodilosso
John Clark
Dave West
Francine Jupiter
Ellyn Crawford
Tim Yarborough

STAFF
Sherryn Craig

GUESTS
Michelle Milgrim, Health Department
Lori McLean, Health Department
Barbara Antley, Department of Family Services
Jennifer Siciliano, Inova Health System

The meeting was called to order at 7:40 pm.

Approval of the Minutes

The minutes of the November 12, 2007 HCAB meeting were accepted as corrected.

Review of HCAB Work Plan

Marlene Blum briefed the HCAB on a phone call she received from Supervisor Linda Smyth. Supervisor Smyth felt that the developmental impact of Inova's capital improvements required community input in the planning process. Supervisor Smyth will ask the Board of Supervisors to convene a Special Study to look at the feasibility of these projects. While Supervisor Smyth would like the participation of the HCAB on the Study, it is not clear whether this will create a conflict of interest, as many of Inova's projects will require a special exception. Supervisor Smyth will speak with the County Attorney's Office to find out the most appropriate way for the HCAB to participate.

Dr. Yarborough was asked to report on the Environmental Committee's progress. There was no new update to report.

Marlene Blum questioned whether the HCAB had satisfied the third priority area in its work plan: Health promotion and the prevention of chronic disease. Lyn Crawford felt

that this priority complemented the first: Public health and environmental issues. The possibility of using MAPP (Mobilizing for Action through Planning and Partnership) to implement this priority area was also discussed. Sherryn will follow up with JoAnne Jorgenson to see if the Health Department has met with the Board of Supervisors on MAPP.

Rosanne Rodilosso brought up the issue of primary care and the lack of general practitioners (GP) and internists in Northern Virginia. She suggested that the HCAB do something to ensure access. Dr. Yarborough said that insurance companies reimburse for diagnostic tests, rather than cognitive skills, and much of what GPs do falls into the latter category. Lyn Crawford added that the salary range for new GPs is significantly lower than other specialties. Bill Finerfrock agreed that until payment policies were aligned with workforce policies, a deficit of GPs would continue.

Bill then suggested having HCAB meetings at district offices. The meetings could be structured around an "open mic night" where health concerns would be solicited from the community. Marlene thought this was a good idea, but cautioned against promising too much. One of the expectations might be that the HCAB would fix the perceived problem. Marlene also suggested that these meetings be structured around a particular topic, like primary care.

Members agreed with the district meeting concept. Given that these meetings would require additional staff time, Marlene asked Sherryn to follow up with JoAnne and Dr. Gloria.

Francine Jupiter asked a follow up question from the MAPP presentation in October. She wanted to know the status of the BOS meetings. She reiterated that HCAB members would be interested in accompanying Health Department staff on these visits. Sherryn will follow up with JoAnne and Julie.

Homeless Medical Respite Program Presentation

Michelle Milgrim from the Health Department and Barbara Antley from the Department of Family Services (DFS) reviewed second year outcomes for the Homeless Medical Respite Program. Before Michelle reviewed the program's history, she thanked the HCAB for their continued support.

In 2004, the Board of Supervisors created a medical respite program for the homeless. The Homeless Healthcare Council defines respite care as "recuperative or convalescent services needed by homeless persons with medical problems—in essence providing sick and injured homeless persons a respite from the dangers of living on the street."

The program has two components: (1) a shelter-based component where home health care would be brought in to clients who needed short-term respite care while in the

shelter and (2) a medical facility component where clients would receive skilled nursing or assisted living care. The program was designed to have 4 male beds, 1 bed for females (when available) and 1 bed in the family shelter (when available). The pilot program kicked off in October 2005 at the Embry Rucker Community Shelter.

During the first year of the program, 31 unduplicated clients were enrolled; 26 were in the shelter-based component and 5 were in the medical facility component. In the second year of the program, staff saw the same unduplicated client count, but 30 were based in the shelter and only 1 in the medical facility component. The program admitted fewer females in the second year and the age of clients ranged from 22 to 65 years of age.

During the second year, applicants had a 29 percent chance of being admitted into the program. Of the 124 assessments that were completed, 88 people were unable to be served. Some clients were ineligible because they were not Fairfax County residents, they did not require respite care or their level of care exceeded the program's length of stay requirement (30 days). Others refused to enter the program because they did not want to relocate to Reston or because they did not want to go into a shelter. Lastly, some clients or case managers did not follow up with the Medical Respite Team to complete their assessments.

Based on the HCAB's recommendation last year, the program began tracking need using a waitlist. During the second year of the program, 9 clients were waitlisted for a bed. Anecdotally, many hospitals did not complete patient assessments simply because there were no beds available. Over the last 4 months, County staff have been meeting with area hospital case managers and have encouraged them to submit the appropriate paperwork for potential candidates, even if there are no beds available. In-services have been conducted at Reston Hospital, Inova Fairfax, Mount Vernon, and Fair Oaks hospitals.

Medical respite referrals came from several sources, but the most common points of contact remained area hospitals and shelters.

The severity of program participants' symptoms were measured at entry and exit using a numerical scale, with a 4 meaning symptoms were poorly controlled and a 0 meaning there were no symptoms. Patients presented with complex pathologies, often suffering from more than one problem. At intake, their diagnosis was often rated a 3, meaning symptoms were poorly controlled and patients needed frequent adjustment in treatment and dose monitoring. The top three diagnoses were (1) musculoskeletal problems (i.e. broken bones), (2) endocrine (i.e. diabetes complications), and (3) cardiac problems.

Clients made remarkable progress during their stay in the Medical Respite Program. With the exception of 2 clients, everyone experienced improvement in one or more of their conditions.

Clients' average length of stay remained stable from year one to year two, averaging 40 and 39 days respectively. There were a few outliers—patients who required extensive care—which skewed the average length of stay upward. For this reason, the median length of stay is a better index of measuring program efficiency. In year two, patients' median length of stay was 33 days.

23 percent (7 clients) had some form of health insurance, either private insurance or Medicare/Medicaid, at program entry. Staff successfully linked those clients without insurance to the Community Health Care Network (CHCN): 71 percent (22 clients) were enrolled in the CHCN during their medical respite stay. Of those 22 clients, 8 continue to receive medical services at CHCN.

Upon discharge from the Homeless Medical Respite Program, many clients (55%) continue to stay in an emergency shelter. 21 percent of clients were characterized as unsheltered, however many of these clients are being served in the Health Department's Homeless Healthcare Program (HHP) and continue to receive medical services. The post-program placement does suggest a greater need for temporary and permanent housing. Several clients exceeded the 30 day length of stay requirement because they were in the process of applying for housing.

Michelle recounted the story of "Dennis" to demonstrate what the Homeless Medical Respite Program is trying to accomplish. Dennis was 51 years-old when he injured his foot at work. He sought treatment at Mary Washington and Inova hospitals. His recovery was going well until he developed Methicillin-Resistant Staphylococcus aureus (MRSA). He was admitted to Inova hospital where part of his leg was amputated. Unable to work, Dennis could not support himself and became homeless. Inova recommended him to the Homeless Medical Respite Program. Dennis was waitlisted. A couple weeks passed before a bed became available. He was admitted into the program and began to recuperate from his surgery. The nurse practitioner was able to secure a motorized wheel chair for Dennis, which increased his mobility. Dennis is currently applying for housing and is looking forward to getting a fresh start.

Barbara Antley discussed additional services provided in the program. At intake, 9 clients had no source of income. The Medical Respite social worker was able to help these clients apply or gain eligibility for social services, including food stamps, General Relief, Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Social Security, Section 8 Housing, Medicaid, and pension benefits. Barbara explained the small number of Medicaid enrollments. In Virginia, clients who are younger than 65 years-old must be deemed disabled before they can qualify for Medicaid.

The average cost to treat a Medical Respite Program Client in year two was $3,371.32 per patient, or $86.44 per patient per day. This includes salaries, transportation, pharmacy, home health care aides, assisted living facility expenses, and other incidentals.

Barbara then discussed some issues that were raised last December when staff presented the program's first year outcomes. It was suggested at that time that the program look into Medicaid reimbursement as a way to defray per patient costs. The Health Department has identified 12 clients who may be eligible for Medicaid, and is piloting reimbursement for one client to see if the Nurse Practitioner services it provides meet the Medicaid criteria for medical respite care. However, DFS home health care aide services provided at the shelter are not eligible for reimbursement. Medicaid provides personal care services for persons who have Long Term Care Medicaid and have been approved for meeting a nursing home level of care. The personal care services are specific for the person who has been approved.

Additionally, the HCAB asked staff to find a better cost comparison for the program's medical facility component. Last year, acute hospital care and nursing home costs were used. This year, at the HCAB's recommendation, staff compared the program to Assisted Living Facilities (ALF). DFS has a contract with Sunrise Assisted Living that stipulates a daily fee structure for Medical Respite clients. On average, DFS spent $46 per day per client for an ALF stay. The Joint Legislative Audit and Review Committee (JLARC) reported that assisted living care in Northern Virginia is $4,118 per month, or $137.27 per day. The Medical Respite program spent approximately $598 for one client (with 2 admissions) to stay at Sunrise. This represents a nearly 30 percent discount off the market rate, or an average savings of $91.27 per day.

There have been some limitations in administering the program. First, the Social Worker position is not a merit position, which necessitates a one-month break during the program year. Because the position does not provide benefits, there has been some turnover in staff. Second, the shelter-component can adversely affect regular shelter operations. Third, there is a continued need for long term care services. The program was unable to serve several clients because they had chronic or end stage illnesses. Marlene Blum suggested that Rosanne Rodilosso take this information back to the Long Term Care Coordinating Council (LTCCC). Sherryn Craig will also provide Rosanne with supporting statistics. Fourth, there is an ongoing need for transitional and permanent housing. Program staff found that many clients exceeded the 30 day stay requirement because they were waiting for housing to become available. Lastly, program staff will continue to improve its data collection efforts.

Barbara reviewed the program's assumptions. When the program was piloted, it was expected to serve 50 shelter-based clients a year. In year 1, 31 clients were admitted followed by the same number in year 2. Clients' average length of stay was not to exceed 30 days in the shelter. In year 1, clients' length of stay averaged 40 days and

in year 2, it was 39 days. When the program was piloted, it was expected to serve 24 medical-facility-based clients a year. In year 1, 5 medical facility clients were admitted; in year 2, one was admitted.

Barbara offered some reasons for why the program has been unable to meet some of these assumptions. Most of the medical respite clients are very sick. Additionally, there is a high prevalence of dually diagnosed (i.e. mental & substance abuse) individuals enrolled in the program. Moreover, many clients stay past the 30 day mark simply because they are waiting to secure housing.

Barbara concluded with the recommendation that the Limited Term Social Worker be converted into a merit position. Implementing this recommendation would require no new allocation of funds.

When asked about possible program expansion, Barbara and Michelle suggested that we wait to see where the 10 Year Plan to End Homelessness goes.

Rosanne asked if the staff would let the HCAB know how long it takes “Dennis” to find housing.

There being no further business, the meeting was adjourned at 9:31 pm.