HEALTH CARE ADVISORY BOARD

Meeting Summary
December 13, 2010

MEMBERS PRESENT
Marlene Blum, Chairman
Bill Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
Francine Jupiter
Ellyn Crawford
Dave West
J. Martin Lebowitz
Rosanne Rodilosso
Ann Zuvekas
Susan Conrad

STAFF
Sherryn Craig

GUESTS
Rosalyn Foroobar, Health Department
Chris Stevens, Health Department
Bob Eiffert, Health Department
Patricia Rohrer, Health Department
Dr. Jean Glossa, Molina Healthcare of Virginia
Judy Cornicelli, Community Services Board (CSB) of Fairfax-Falls Church
Anne Rieger, Inova Health System
Jennifer Siciliano, Inova Health System

Marlene Blum called the meeting to order at 7:35 p.m.

Approval of the Minutes

Richard Hager's name was corrected to Robert. The minutes from the November 8, 2010 HCAB meeting were accepted as revised.

Brightview Senior Living

McGuire Woods, on behalf of Brightview Senior Living, requested a meeting with HCAB representatives to obtain information on the HCAB's Special Exception Application (SEA) review criteria, including the HCAB's concern about access to care for low income residents. Marlene Blum and Rosanne Rodilosso agreed to meet with Brightview representatives on Thursday, December 2 at their attorney's office.

Brightview Senior Living has submitted an SEA to build an assisted living facility (ALF) in Great Falls. Ms. Blum explained the Auxiliary Grant program to the applicant and the rationale behind the HCAB's recommendation that 4% of ALF beds be set aside for low income residents.

Ms. Blum explained that the 4% recommendation is voluntary, but since 1996, the HCAB has made this request of all ALF applicants and most have been accommodating.

Ellyn Crawford asked if the HCAB would be interested in having a presentation from organizations providing in home care to the elderly. On behalf of the Long Term Care Coordinating Council (LTCCC), Bob Eiffert said that the council has not addressed home health care from a regulatory, advisory, or quality standpoint. Rosalyn Foroobar said that home health care is regulated, but that companion care is not.

Ms. Blum suggested that the HCAB meet with the new Long Term Care Ombudsman to address these issues. Ms. Foroobar also suggested that the Department of Family Service's (DFS) Division of Adult and Aging present in tandem with the Ombudsman. Sherryn Craig will work to schedule these presentations.

Health Care Reform

Ms. Blum distributed a December 2 memorandum from Deputy County Executive Patricia Harrison to the Board of Supervisors on Health Care Reform. The County is convening a Health Care Reform Taskforce comprised of community members and county staff, representing behavioral health, social services, and public health sectors, and co-chaired by Ms. Harrison and a community member. As part of its charge, the task force will analyze data, trends, federal policy, state guidance and requirements, legislation and external initiatives which have the potential to impact health care reform efforts. Particular emphasis will be given to implications of and need for workforce development, training, utilization of new technologies and pursuit of alternative/new revenue sources for enhancement of the Fairfax County health safety net system. The task force members will engage existing boards, authorities and commissions, providers in the community and experts in public health policy throughout the process.

The BOS Human Services Subcommittee will take up health care reform at its December 14 meeting.

Update on Commonwealth Care of Roanoke

Rosanne Rodilosso attended a LTCCC subcommittee meeting where a Commonwealth Care of Roanoke (CCR) representative provided information and answered questions regarding CCR's acquisition of Inova's Cameron Glen Care Center (ICGCC) in Reston, Virginia and Commonwealth Care Center (ICCC) in the City of Fairfax. Ms. Rodilosso reported that Smith/Packett-Med-Com, LLC is the development entity for the project; the operating entity is CCR. CCR owns and operates 11 facilities in Virginia. Inova retains ownership of the buildings and property. CCR has signed a three year lease agreement with Inova that can be extended up to five years. CCR's lease began October 1, 2010.

At the end of its lease, CCR will build two new facilities. CCR is considering two sites: The first is in Sterling (Loudoun County). The facility will house 150 patients and a 30 patient Alzheimer's unit. Vent care will also be provided. The second site is an old Sunrise property in Oakton. Neither facility will be licensed for assisted living.

CCR plans to retain the ICGCC and ICCC workforce. No information was provided on CCR's costs.

Ms. Blum informed the HCAB of a conversation she had with Inova's Robert Hager, Assistant Vice President, Long Term Care. As part of their Certificate of Public Need (COPN) application, CCR guaranteed that the beds in their two new buildings would be dually certified for both Medicaid and Medicare. Thus there will be no loss of Medicaid and Medicare beds in Northern Virginia, and there may actually be a slight increase, since not all of ICGCC's beds are currently certified for Medicaid. Of course, this potential increase may not be in Reston.

When the divestment occurred, there were 19 patients receiving uncompensated care (combined total for both facilities—ICGCC and ICCC). That means no Medicaid, no Medicare, no Auxiliary Grant. These patients were (and are) in assisted living, long term care, and skilled nursing.

Inova will continue to pay for care for these uncompensated care patients as well as for new ones. Most of Inova's uncompensated care patients are in fact not in Inova facilities, but in other facilities. These people are Inova's acute care patients who must be discharged from the hospital to long term care, but who are uninsured, low income, and ineligible for other forms of reimbursement.

Auxiliary Grants (AG) for assisted living are tied to individuals, not beds. However, the 20 AG recipients currently living at ICGCC will have to move to other facilities, since CCR will be operating nursing homes, not providing assisted living. Mr. Hager said that staff would work with these residents and their families during the next three years to find appropriate facilities for them. Ms. Blum stated that finding alternative placements might be difficult given that most ALFs accept only a few AG recipients and are most likely at capacity. Dr. Lebowitz noted that there is a certain amount of attrition that comes with this population and AG placement may not be an issue. Ms. Blum agreed, but recommended that the HCAB should continue to monitor these developments.

Inova will continue to own the assisted living wing at Commonwealth Care in Fairfax City, and Sunrise will continue to operate it. This facility has 60 beds, and four or five of the residents are covered by the AG program.

Mr. Hager said he would be happy to attend another HCAB meeting to answer questions.

Francine Jupiter asked if ICGCC's ALF beds will be converted to all nursing home beds at the end of three years. Jen Siciliano will follow up with Mr. Hager and report back to the HCAB.

Community Health Care Network (CHCN)

Chris Stevens, Community Health Care Network (CHCN) Program Director, and Dr. Jean Glossa, CHCN Medical Director, provided a brief overview of the County's primary health care

program for low-income and uninsured residents. The program, now in its 20th year of operation, served 26,000 unduplicated patients in Fiscal Year (FY) 2010, an increase of 30% over FY 2009.

CHCN's services include:

- Preventative care
- Episodic and long-term chronic care
- Acute care – either by appointment or walk in
- Family Planning one evening per week at the Women's Walk-In Clinic
- Nutrition Counseling (in both English and Spanish) for diabetic patients, including a partnership with George Mason University's (GMU) Masters of Public Health (MPH) nutrition students
- Mental health (including psychiatry from the CSB)
- Same-day service (by appointment or walk in) and after-hours consultation with Registered Nurses (RN) and/or physicians on weekends and evenings

Other services that are available onsite include:

- Laboratory, including three pick-ups from Lab Corps
- Onsite pharmacy
- Prescription Management Program
- Onsite radiology (limited)
- Radiology scheduling at Inova
- Physical Therapy & Surgery Center (Inova)
    - Inova sends a physical therapist four days a week, five hours each day to each center (Demand at South County requires two days).
    - Beyond excising a lesion, few surgical procedures are performed at CHCN. Inova's surgeons case manage patients from beginning to end.
    - Dr. Pullarcat has been pivotal to the success of the Surgery Clinic. He recently recruited a neurosurgeon that has treated two individuals with brain tumors who were waiting for referrals to the University of Virginia (UVA).
    - Support for Inova's Surgical Clinic will continue to expand. Inova's new Chief of Surgery, Dr. Bronn, has a long history running Resident clinics for low-income/uninsured patients.
    - Dr. Glossa said that CHCN continues to follow up with all Surgical Clinic patients, but does not round on them in the hospital.
- Specialty care – scheduled by medical social workers among 290 specialists
- Enrollment social work – 17 DFS staff are deployed to the Health Access Assistance Team (HAAT), which enrolls patients in a number of safety net programs and services.

CHCN has three basic eligibility criteria. First, an individual must be a resident of Fairfax County or the cities of Fairfax or Falls Church. Second, income must be at or below 200% of the Federal Poverty Level (FPL). Third, the individual must be uninsured or demonstrate that his/her insurance is not affordable.

CHCN's budget is $9 million. However, the program is able to leverage other resources, including $15 million in medication through the Pharmaceutical Assistance Program and Bulk Shipments and $3-4 million in donated specialty care services.

CHCN represents the public/private partnership model. The County provides leased/owned space. CHCN administrative staff contracts with a vendor to operate the three health centers, specialists, ancillary services, Public Health Nurse Liaisons, and coordinates access to health care activities with DFS. Molina Healthcare operates the three health care sites, the Nurse Advice Line, Clinical staff, Specialists and Ancillary Services. Community providers, like Inova, treat patients in charity care programs.

Since CHCN uses paper medical records, Bill Finerfrock asked what the system's added costs are and whether an Electronic Medical Record (EMR) would increase efficiencies. Inova has provided CHCN with funding to begin the EMR process, since the program is not eligible for federal funding. Ms. Stevens said that CHCN is in a holding pattern until a vendor is selected, but she expects implementation to begin in late spring or early summer. Dr. Lebowitz cautioned that there is a transition period with EMRs and that the benefits are not immediate.

Dr. Lebowitz asked how CHCN was integrating junior and senior Virginia Commonwealth University (VCU) students who spend two years at Inova into its program model. Dr. Glossa said that she has a meeting with Inova in January to discuss this opportunity. CHCN currently has an agreement with UVA, which sends medical students, who are between their first and second years, to a CHCN Center in the summer. CHCN also has residents from Georgetown University's family practice, in addition to GMU nursing and nurse practitioner students and a nurse practitioner student from Marymount.

Dr. Lebowitz recommended that CHCN be part of students' rotations. Dr. Glossa agreed, but cautioned that there are productivity issues involved with taking on medical students. Ann Zuvekas cited several studies that showed substantial benefit in integrating community health care providers with medical school curriculum, but emphasized that the costs (i.e. supervision and space) were not negligible. Dr. Lebowitz argued that CHCN could "subliminally recruit" physicians to move to Fairfax County by offering a formal rotation in community health.

Ms. Rodilosso also underscored the shortage of primary care physicians and suggested that policymakers provide incentives that would encourage young physicians to choose a primary health career path.

CHCN Mental Health/Primary Care Collaboration

Dr. Glossa briefed the HCAB on the integration of mental health and primary health care services at CHCN. An Institute of Medicine (IOM) study found that patients with Serious Mental Illness (SMI) lived 25 years less than people without SMI. Even more alarming was that the causes of premature death in SMI patients were preventable.

Dr. Glossa observed that it is difficult getting patients to seek psychiatric care; it is even more difficult getting them into primary care. Conversely, primary care patients with mental health

needs do not feel comfortable going to an outside mental health setting. Providing primary care and mental health in one location will have greater benefit to more people.

In 2002, the CSB and the CHCN applied for and were awarded a CAP/HRSA grant. The grant provided funding to hire a mental health therapist for the CHCN. Lessons learned from the grant underscored the need for provider collaboration. Separating behavioral health from primary health care was ineffective. Integrating services required a formal liaison between the CSB and the CHCN to facilitate referrals, and basic mental health medications needed to be added to CHCN's formulary.

At the end of the CAP/HRSA grant, CHCN continued to fund a full time, bilingual mental health position. In 2007, a small pilot was implemented to deploy a CSB psychiatrist to a CHCN health center four hours per month. This required CHCN to add more mental health medications to the formulary, improve the CSB referral process, and take a team approach (i.e. a mental health counselor and a psychiatrist) to care, allowing more patients to be treated.

By 2008, CHCN dedicated one office for mental health at each center. CHCN also deployed a primary care physician to Woodburn Mental Health four hours per month. Judy Cornicelli, a psychiatric nurse with the CSB, coordinates CHCN enrollment onsite at CSB as well as any follow up that may be needed. Based on collected data, about 75% of Woodburn patients make and keep their appointments at CHCN. Without a liaison, Dr. Glossa speculated this number would be much lower.

CHCN visits have grown increasingly popular among CSB-referred patients - so much so that administrators have increased the number of deployed psychiatric hours to CHCN to three full days. One CSB psychiatrist covers all three CHCN sites, and the same psychiatrist receives patients at the CSB.

In 2009, a second CHCN mental health therapist was hired. CHCN began sending staff to enroll mental health clients at the CSB Springfield site quarterly.

This year, CHCN has expanded care to a second CSB site – Gartlan Center. The CHCN is able to conduct Domestic Violence screening at all CHCN Women's Health Walk-in Clinics and all CHCN patients are now screened for depression. Additionally, a CSB Psychiatric Nurse Practitioner has been deployed one day a week to a CHCN Center.

Despite the success of the primary care-mental health collaboration, there is still more that can be done, including:

- Hiring a full time deployed primary care provider to a CSB site
- Implementing shared medical records and enhancing electronic communication
- Opening a co-located facility for on site integration

Mr. Finerfrock asked Dr. Glossa if any outcomes analysis had been performed to document patient improvements and institutional efficiencies. Dr. Glossa replied no but mentioned a possible collaboration with GMU's Center for Social Services. Dr. Glossa stated that the names and output (e.g. weight, hemoglobin levels, etc.) for every patient are being tracked so a

retrospective analysis is feasible. To demonstrate the cost controls of an integrated model, Mr. Finerfrock suggested a review of emergency room (ER) utilization for patients receiving care in a traditional, non-integrated model versus patients receiving care in the new, integrated model.

Ms. Blum echoed Mr. Finerfrock's recommendation, stating that the local governing body did not need to be persuaded, but documenting clinically and financially the model's outcomes would justify requests like a co-located facility.

Susan Conrad asked what trends Dr. Glossa was seeing in mental health, citing the unmet needs of the 20-30 year-old population. Ms. Cornicelli mentioned several ways that people in need of mental health services could contact the CSB: Coordinated Services, hospitals, ER, and community information directories. CHCN also screens for depression, and Dr. Glossa felt that primary care providers are getting better at identifying patients with mental health needs.

Other Business

Ms. Siciliano announced a translational research partnership between Inova and the Department of Defense that will focus on gynecologic cancers. Inova will provide laboratory space. Ms. Siciliano will arrange a tour for any HCAB member who is interested.

Dr. John E. Niederhuber, formerly from the National Cancer Institute, has accepted the position of Executive Vice President, Inova Health System/CEO Inova Institute for Translational Research and Personalized Medicine:

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