

HEALTH CARE ADVISORY BOARD

Meeting Summary
November 13, 2013

MEMBERS PRESENT

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

STAFF

Sherryn Craig

GUESTS

Robert Hager, Inova Health System
Dr. Loring Flint, Inova Health System
Karen Berube, Inova Health System
Michael Forehand, Inova Health System
Dr. Eapen, Medical Society of Northern Virginia
Carol Jameson, HealthWorks for Northern Virginia
Dr. Jean Glossa, Molina Healthcare
Pat Harrison, Office of the County Executive
Rosalyn Foroobar, Health Department
Robin Mullet, Health Department
Arsenio DeGuzman, Health Department

Call to Order

The meeting was called to order by Marlene Blum at 7:39 p.m.

October Meeting Summary

The minutes from the October 16 meeting were accepted as submitted.

InovaCares for Seniors PACE Program

Robert Hager, Assistant Vice President, Long Term Care Services and Program Director, InovaCares for Seniors PACE, addressed questions from the HCAB about PACE's current and future enrollment. In its application to the Centers for Medicare and Medicaid Services (CMS), the program was approved for 120 participants per site. That number has been adjusted downwards to 105-110 per site. Currently, there are 46 participants in the InovaCares for Seniors program.

Mr. Hager explained that CMS initially approved the program to operate in more than 70 zip codes in the Northern Virginia region. However, the Virginia Department of Medical Assistance Services (DMAS) required a phase-in period, restricting the program to just 40 of those zip codes. Given that enrollment is not on trend with the program's initial projections, Inova is working to secure approval from DMAS to open the program's service area to all 70 CMS-approved zip codes. Mr. Hager is confident that opening the catchment area to additional zip codes in Fairfax County, Arlington County, Prince William County, and the City of Alexandria will increase referrals and program enrollment.

Mr. Hager discussed some of the contributing factors affecting PACE's rollout. The enrollment rate in the Northern Virginia market is slower than Richmond's PACE rate. Educating and providing information to families with Medicaid has been challenging. The program is restricted from direct marketing to individuals, including the dual-eligible market. While PACE can make presentations at income-based senior centers, it cannot market door-to-door, putting it at a disadvantage when compared to home health aide agencies.

PACE's primary competitor is the Medicaid Elderly Disabled Consumer Directed (EDCD) Waiver. PACE is limited to enrolling participants on the first of the month. Seniors requiring immediate services often choose the waiver program over PACE. For those individuals who are currently receiving home health services, it becomes difficult for them to make a change. Mr. Hager said that they have grown accustomed to having someone in the house 40 hours a week, regardless of whether or not direct care is being provided. Enrollment in PACE usually results in home health care hours being cut in half.

Mr. Hager also took responsibility for underestimating the amount of education required for front-line workers, including the County. While assessments are now being conducted in a timelier manner, communicating what PACE is and how comprehensive a health plan it is has been challenging. Based on the experience of other PACE programs, the first three years are the most difficult.

Dr. Michael Trahos, DO, asked what happens to the primary care physician (PCP)-patient relationship for those who are Medicaid eligible. Mr. Hager said that PACE is designed around the PCP: the physician-to-participant ratio is 1 to 110. InovaCares for Seniors has 85-90 specialists in its network. If a participant wants to continue seeing her PCP, PACE will pay for it out of network. However Mr. Hager said that after 60 days of participating in PACE, individuals are no longer requesting out-of-network PCP care. Participants find that they are seeing the physician at PACE more frequently than their own doctors.

Participants' relationships with their PCPs have been identified as a training issue for eligibility workers. Technically speaking, people who enroll in the program are

supposed to give up their physician, but as Mr. Hager explained, the process is not black and white, and patients always have the option to dis-enroll at any time.

Dr. Trahos, DO asked if the Inova Medical Group (IMG) are included in PACE's network of specialists. Mr. Hager said that PACE has a contract with Fairfax Family Practice. Dr. Trahos, DO expressed his opinion that one of the reasons PACE is experiencing enrollment issues is because of a disconnect between PACE and the pipeline of community physicians, and added that community physicians do not want to lose their patient base and therefore they are reluctant to discuss PACE with their patients.

Mr. Hager asked to rebut this point by saying that PACE does not fall under Medicare Advantage and is not a Medicare Advantage health plan. The program is primarily designed around dual eligibles who are on the cusp of entering a nursing home. He said that in practice, the participant-patient relationship is no different than what happens when someone enters a nursing home. They do not have the same PCP after they enter an institutional care setting. The difference is PACE coordinates care to seniors so that they can remain in their homes and part of their communities.

Mr. Hager welcomed anyone who was interested to come and visit the InovaCares for Seniors Program. HCAB members who wish to visit should contact Mr. Hager directly.

Introduction of Arsenio DeGuzman

Arsenio DeGuzman was introduced as the Community Health Care Network (CHCN) Program Director. Mr. DeGuzman comes to the Health Department from the Department of Management and Budget, and prior to that, the Department of Human Services Administration. He has more than 20 years of health care administration experience. Sherryn Craig will send out Mr. DeGuzman's contact information to the HCAB.

Panel Discussion of *Pro Bono* Specialty Health Care

At the October 16 HCAB meeting, Rose Chu, Chairman of the CHCN Community Advisory Committee (CAC) reported on problems among safety net patients accessing specialty health care services. Given the complexity of the issue, the HCAB agreed to convene a panel to discuss the issues and identify potential solutions. Representatives from the Medical Society of Northern Virginia, HealthWorks for Northern Virginia, CHCN, and Inova Health System were invited to attend.

Dr. Eapen provided an overview of the Medical Society of Northern Virginia (MSNV)'s ongoing efforts to coordinate pro bono specialty care. Dr. Eapen is a primary care provider and has worked with safety net patients as a former physician with the Jeannie Schmidt Free Clinic (now HealthWorks for Northern Virginia). She underscored the need for specialty care among the region's low income patients.

Project Access of Northern Virginia (PANV) was started in 2007 and organized by the MSNV as a 509(a)3 nonprofit organization. The mission of PANV is to provide access to no/low cost specialty health care to the high risk, uninsured, low-income in the Northern Virginia area to patients who receive primary care at area safety nets. There are many successful examples of Project Access: Asheville and Roanoke, Virginia are two.

Because of the difficulties involved with volunteer specialty physician recruitment and the overwhelming need for specialty care, PANV was unable to fulfill its mission, and by 2012, it had exhausted its resources (staffing, time, and money). Several members of the Medical Society felt the mission of PANV was too important to discontinue, and Dr. Eapen volunteered to become the pro bono PANV director.

PANV is an entirely grassroots-based organization. Since taking over PANV in February 2013, Dr. Eapen has received 250 referrals for specialty care. Dr. Eapen reported that she had been able to fill only one-half to two-thirds of those requests.

When asked what the difficulties were in recruiting specialty physicians to participate, Dr. Eapen said that many providers are in private practice and that it was becoming harder for these physicians to keep up with new regulations and outside requirements, leaving them with little time and less interest in providing *pro bono* care. Other practices, she said, were trying to deal with the economic realities of the past few years and were organizing into larger groups or being bought out by other companies. Dr. Eapen said the consolidation of private practices had resulted in some physicians feeling that they no longer had the autonomy to provide pro bono care to safety net clients.

As a result, safety net providers are pursuing other alternatives to specialty care access for their patients, namely the University of Virginia's (UVA) Medical Center. Dr. Eapen voiced her personal frustration: a community with such wealth, an ample supply of physicians and some of the top rated hospitals in the country should not be sending its most vulnerable to UVA, especially for routine specialty care. Academic medical centers should be reserved for those patients with rare, esoteric, or complicated cases.

Dr. Eapen shared that in her conversations with a few practices that were recently acquired by the Inova Medical Group (IMG), physicians conveyed that they no longer had the authority to provide pro bono specialty care. However, Dr. Eapen has worked with Karen Berube and has clarified that IMG physicians have the independence to decide if they do or do not want to provide *pro bono* care. Dr. Eapen concluded that she hoped Inova would encourage its providers to participate in PANV.

Marlene Blum noted that referrals and access to specialty care has been a problem for years. The reason for the HCAB facilitating a discussion on the issue is that there appeared to be new or increasing difficulties that may be contributing to an already existing problem.

Robin Mullet, Assistant Director, CHCN, said that in 2011, CHCN made almost 14,000 referrals for specialty care. Prior to June 30, 2013, the CHCN had 294 specialists within its specialty care network who received a modest stipend for providing care to CHCN patients. However, as some of these specialists retired, fewer physicians were coming on board to replace those who had left practice. Others indicated that they would continue to treat patients for whom they had already seen, but would not accept anyone new. So CHCN has had no choice but to send its patients to UVA.

The CHCN supports the idea of building a centralized, coordinated specialty network, which would minimize the burden to any one participating physician. PANV's mission to recruit specialists in the community, organizing them to treat safety net patients, is an idea that many of the region's safety net providers embrace. Based on existing trends and indicators, the CHCN is sending more of its patients to UVA.

Dr. Jean Glossa, CHCN's Medical Director, shared her involvement in PANV's recruitment efforts. The program's initial phase met with good results, but they were not sustained. In its second phase, the PANV Program was reorganized as NOVA Specialty Access, securing grant funds to enhance its recruitment efforts; participation briefly increased, but then stagnated.

In Dr. Glossa's experience with PANV, paying physicians or providing a stipend was never a barrier to specialty care recruitment. In her conversations with providers, only three issues were ever raised:

- The need for fairness was identified as physicians' top concern. In areas where Project Access was successful, a shared responsibility among a community's providers was key: all physicians were referred one patient before anyone received two.
- Concerns over diagnostic tests and how patients would access these services diminished after Inova's charity care policy was explained. Safety net clients were enrolled in Inova's financial assistance programs and would have ample access to any tests or services a participating specialist ordered.
- Last, providers had reservations about treating patients without an identifiable medical home. Safety net providers recognized these concerns and agreed that a specialist's time should be focused on tertiary, not primary care issues.

In Dr. Glossa's opinion, PANV provides a streamlined way to refer safety net patients to specialty care, and satisfying the three issues outlined above would ensure its success. Dr. Glossa said that it is now standard operating procedure to have all CHCN patients fill out UVA's charity care application. This application is included in patients' packet of materials that they receive at their first CHCN visit. Dr. Glossa felt that UVA should be just one tool in CHCN's specialty care tool box, but unfortunately, at this time, it has become the only tool.

When Ms. Blum asked Dr. Glossa why there was resistance among local doctors to participate in PANV, she reiterated many of the concerns that Dr. Eapen had shared. Changes in the economy resulted in many doctors dropping out the pro bono network. Other physicians expressed frustration that the burden was not shared equally and they were tired of being repeatedly asked and expected to do more – all on top of the extra things (billing, EMRs, documentation, etc.) they were required to do. Because of perceived inequities in the pro bono network, many physicians adopted a blanket “no” policy.

In regions where Project Access has been successful, Dr. Glossa underscored the importance of leadership and partnership among its health system and medical society.

Carol Jameson, Associate CEO, HealthWorks for Northern Virginia, agreed with all the panelists’ comments. She highlighted the need for coordinated specialty care recruitment; having individual safety net providers calling an office manager of a specialty practice in order to secure their own deal was inefficient and ineffective.

Ms. Jameson added that specialty physicians were reluctant to care for patients with psycho-social issues related to poverty (e.g., unsecure/unsafe housing, unstable employment, mental health status, etc.). HealthWorks has tried to work with providers to assure them that patients have access to social workers who are able to provide psycho-social supports.

Ms. Jameson agreed with all the speakers that UVA is not a viable, long-term solution for addressing the specialty care access problem. She said that many patients who are referred to UVA do not have transportation. They work two to three jobs and do not have sick or annual leave in order to travel to Charlottesville. Moreover, their health status is oftentimes poor because they delayed preventive and primary health care, which has resulted in their symptoms/conditions becoming more acute and requiring advanced-level care. Despite all the barriers that were identified, though, Ms. Jameson felt the problem was solvable.

Karen Berube, Inova’s Assistant Vice President(AVP), Population Health Management, argued that it was important for Inova to be seen, like CHCN and HealthWorks, as a safety net provider. Like the other panelists, Ms. Berube said that Inova operates safety net clinics across the community, and they too experience the same problems getting patients access to specialty health care.

Ms. Berube acknowledged that Inova’s transitional care and safety net clinics are also sending patients to UVA. She stated that UVA is funded at a higher level than Inova is to provide charity care. Moreover, many of Inova’s specialists are in private practice, and as such, they have the autonomy to decide who they will and won’t see. She related that some of Inova’s specialists use a barter and exchange system to provide

specialty care. One cardiology practice may agree to see one neurology practice's low income clients so long as the other reciprocates in kind.

Ms. Berube agreed that a collaborative approach to specialty care referral and recruitment would be helpful. While she explained that IMG physicians are not restricted or limited in taking *pro bono* clients, she also said that Inova does not have the authority to encourage or require that they accept safety net clients. Doing so would undermine physicians' autonomy.

Members of the HCAB disagreed with Ms. Berube. Bill Finerfrock said that the question of fairness is important, but its answer lies in the eye of the beholder. He suggested that Inova take measures, to the extent possible, to improve its communications with its physicians and let them know that providing *pro bono* charity care is not only acceptable, but it is required under Inova's lease agreement with the County.

Ms. Blum thanked Mr. Finerfrock for his comment and read Section 7 of Inova's lease agreement with the County, which addresses the restriction of specialty and referral programs as well as the notification process for implementing those restrictions.

Dr. Loring Flint, Executive Vice President and Chief Medical Officer of Inova, stated that Ms. Berube's comments were inappropriate and should be retracted. He said that Ms. Berube's job did not include hiring and firing physicians and that she had no right to speak on matters pertaining to them.

Dr. Flint sympathized with the dearth of providers, especially among certain specialties: dermatology, gastroenterologists, plastic surgery. CHCN and HealthWorks are not unique in trying to access certain specialists. Dr. Flint said that while Inova has been expanding its inpatient specialty lines (e.g., cardiology, neurology), there are some specialty areas (gastroenterology, ophthalmology, dermatology) that have been especially difficult to grow.

More importantly, he reported that there have been no changes to Inova's charity care and financial assistance policies that would prevent physicians from accepting/treating safety net clients. Among those practices that indicated something contrary, Dr. Flint has contacted them personally. Ten percent of one practice is now exclusively dedicated to providing *pro bono* care and a cardiology practice acquired through IMG has reversed its initial decision not to accept safety net clients.

He also shared that Inova is redoubling its efforts to educate its front line staff on the system's charity care and financial assistance policies in order to mitigate future miscommunication.

Ms. Blum thanked Dr. Flint for working with his staff to clarify Inova's policies and dispelling any misperceptions about IMG providers' ability to treat safety net clients.

Mr. Finerfrock did not agree with the suggestion that community health or academic medical centers are paid to provide charity care. In light of that characterization, it was not unreasonable to see why providers would question their need to treat indigent patients if it was believed that others were being compensated to do so.

It was Mr. Finerfrock's opinion that the reason fewer doctors are agreeing to treat safety net clients is because of all the nonclinical activities they are required to perform, most for which they are not compensated.

Lastly, Mr. Finerfrock underscored the call for leadership. Providing care to low income clients is a shared responsibility. Mr. Finerfrock felt that physicians, whose residency education was partially financed with taxpayer dollars, should reconsider the provision of *pro bono* care as taxpayer reimbursement.

Dr. Yarboro encouraged the panel to look at those areas of the country where access to free specialty care had been successful. Additionally, he suggested waiving credentialing fees as one incentive for having greater participation among specialty providers to treat safety net clients. Dr. Flint felt that waiving this requirement would make hospitals irrelevant.

Dr. Michael Trahos, DO disagreed with the suggestion that physicians, vis-à-vis their residency, should give back based on what they had been given, citing taxpayer compensation as incommensurate with the work provided and the costs of living. It was his opinion that fewer physicians have a desire to participate in charity care networks because of regulatory changes affecting physician payments and reimbursements.

Dr. Trahos, DO stated that health care was a three-legged stool, comprised of beneficiaries, hospitals, and community physicians. He felt that policies to reform health care have done a good job focusing on the first two but not the last. It was his belief that omitting community physicians from public policy decisions would jeopardize the stability of the health care system.

Ann Zuvekas asked about patients' average wait times in accessing a specialist. Ms. Mullet stated that CHCN South County patients were having difficulty accessing physical therapy at Inova. However, CHCN is working with Ms. Berube and there are discussions about moving PT back to the clinics after the first of the year. With respect to accessing UVA, Ms. Mullet said it takes about three months for UVA's financial aid office to process a patient's charity care application. After a patient has received approval, it can take anywhere from one to three months before an appointment is scheduled.

Dr. Glossa and Dr. Flint agreed to talk offline about securing greater access to specialist providers within the Inova network.

Ms. Zuvekas stated that in places where access to free specialty care has been successful, hospitals have taken the lead in coordinating care. She cited Boston, Massachusetts as an example. In Austin, Texas, one Catholic hospital made it clear that in order to receive attending privileges, all practitioners would be required to provide charity care. Delaware also had an indigent care system in place, which was organized by its state's medical society.

Ellyn Crawford asked panelists if a volunteer consultant could propel PANV forward. Dr. Glossa said that previous iterations of PANV have relied on grant funding and paid coordinators, but even with these resources, the fact remains that only a small number of Northern Virginia's community physicians are members of the medical society.

Mr. Finerfrock reiterated that among physicians in the Inova system, the provision of charity care must be treated as a requirement. By virtue of Inova's tax exempt status and its lease agreement with the County, Inova must communicate those requirements to its providers. When physicians or practices join the Inova System, they accept, as part of their arrangement with Inova, the terms of the lease agreement with the County, especially those sections governing charity care. Inova is in a position to foster among its providers a sense of obligation to the community.

Ms. Zuvekas asked about implementing some mechanism for follow up in order to ensure that better and more frequent communication is occurring among organizational leadership.

Mr. Finerfrock also suggested that other hospitals be included in the discussions. Ms. Zuvekas agreed and suggested that the principals all meet in the same room. Ms. Chu reminded the HCAB that at the last CAC meeting, members learned that some CHCN clients continue to receive bills and invoice statements from Inova. Ms. Berube said she was aware of the issue and was continuing to look into it.

Update on CHCN Budget Reductions

Rosalyn Foroobar, Deputy Director for Health Services, provided an update on the impact of FY 2014 budget reductions on CHCN. The funding cuts implemented on July 1, 2013 totaled \$751,826, or an eight percent decrease in CHCN's budget. The reductions included:

- Elimination of in-house radiology services (\$245,000)
- Reduction of specialty care (\$250,000)
- Elimination of one (1/1.0 FTE) physicians or nurse practitioner (\$219,000)
- Reduction of other/miscellaneous expenses – contractor overtime, office supplies, training (\$37,826)

With respect to eliminating in-house radiology services, Ms. Foroobar felt that CHCN has weathered the cuts; CHCN radiology services access, quality, and timeliness continue to be commensurate with professional and community standards. Overall, in-house specialists have been very pleased with the higher quality and short turnaround times of outside x-rays. Providers have not expressed any major concerns about patients now needing to leave the health center for x-rays.

Ms. Mullet said that CHCN has surveyed its patients and no complaints or issues have been raised. With respect to TB chest x-rays, 100 percent of the films ordered have been received. Compliance among ortho and other x-rays varied by referral source, from 99 percent among patients referred to Inova Fair Oaks Hospital to 72 percent for those referred to Inova Mount Vernon Hospital. In order to have more consistency among referrals, CHCN has instituted follow up calls to providers. A suggestion was also made to outreach to Reston Hospital for x-ray services.

As discussed during the panel discussion on specialty care, the impact of eliminating \$250,000 from specialty paid contracts exacerbates an already insufficient supply of local specialists. CHCN's specialist network has decreased from 294 to 63 providers. CHCN has also increased its utilization and reliance on non-local (UVA) specialty services, resulting in an increased workload on referral specialists to assist with UVA's financial screening process and appointment scheduling.

Significant gaps exist in the orders for UVA specialty services and the actual appointments scheduled. There are major time delays in implementing treatment plans. At UVA, the time between charity care application and approval ranges from 54 to 96 days; and once approved, the number of days until the actual medical appointment is scheduled ranges from 36 to 79 days. The impact of the cut has increased hardships, travel costs, and time lost working for already low income, uninsured patients needing to travel long distances to keep specialist appointments.

Ms. Mullet will follow up on funding sources for charity care at academic medical centers, like UVA. The HCAB also requested greater granularity on specialty care referrals by disease categories. To control for the seasonality of certain medical services, CHCN staff will also match data for prior and subsequent fiscal years by month.

At the end of May 2013, there was a full-time physician vacancy at CHCN-North. This permanent reduction (salary, fringe, malpractice, license, and associated operating expenses) has not been filled. Currently, there are no significant impacts to the number of visits/slots available to enrolled patients, the number of people on the waiting list, or the time between a person's placement on the waiting list and his/her enrollment appointment. However, CHCN staff cautioned that the data covered a three month period, and a contract physician position, which has been temporarily filled, will

become vacant after December 2013. Moreover, the future availability of Kaiser's Nurse Practitioners and Physician Assistant remains uncertain.

Ms. Zuvekas observed that based on the estimated wait times for CHCN enrollment, resources are not equally distributed among the three clinic sites. Bailey's clients are faced with a year or more waiting time, while North and South Counties are averaging four months. Ms. Mullet will forward additional statistics on how many patients and the number of visits each office is seeing.

Ms. Foroobar said that the waiting list numbers are beginning to decline. Ms. Blum cited similar trends in the number of calls to Coordinated Services Planning requesting assistance for human services needs, which may suggest that the economic outlook for the region may be improving.

Health Department staff will continue to monitor the impact of the FY 2014 cuts to CHCN and keep the HCAB apprised of any changes to patient care.

There being no further business, the meeting adjourned at 9:51 pm.