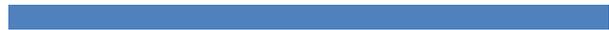


# ACTION PLAN

Fairfax County Health Care Reform  
Implementation Task Force  
November 2012



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## Table of Contents

Background .....	3
Process .....	4
Post-Presidential Election—National Trends and Implications for Virginia .....	5
Vision for Systems Change .....	8
Strategies and Work Plan .....	10
Organization Alignment .....	10
Service Integration Efforts .....	12
Revenue Strategies and Policies .....	15
Information Technology Supports .....	17
Enrollment and Access Business Practice Strategies .....	20
Leadership and Governance Options .....	23
Evaluation and Planning .....	24
Summary .....	26
Appendix I: Fairfax County: Health Care Reform Implementation Task Force .....	28
Appendix II: Principles for Discussion on Health Care Reform Implementation .....	30
Appendix III: Current Health Services System and Access to Existing Safety Net Services .....	31
Appendix IV: Task Force Accomplishments .....	32
Appendix V: Summary of Boards, Authorities, and Commissions Input on George Mason University Consultant Report .....	33
References .....	46

## Background

The Health Care Reform Implementation Task Force was established in December 2010 to develop a community and Fairfax County government response to requirements of federal Health Care Reform. Its charge was to:

- Study the provisions of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010, and analyze the operational impact of the various requirements;
- Recommend strategies for implementation, to include policy decisions related to future structuring of safety net services, incorporating analysis of existing, revised, and new health insurance coverage opportunities; and
- Implement, administer, and evaluate agreed upon actions.

*See appendix I for Task force Charter and proposed tasks and deliverables.*

On January 31, 2012, the Health Care Reform Implementation Task Force presented 12 initial recommendations to the Board of Supervisors. Guided by a vision of increased access to healthcare, better management of care availability, appropriate and affordable care, prevention and quality of life standards, the five guiding principles and planning assumptions for this work included:

- Support individual responsibility;
- Seek system integration and optimization;
- Pursue sustainable system financing;
- Ensure accountability, transparency and improvement; and
- Pursue advocacy and stewardship consistent with the county's mission.

George Mason University was hired to provide consultation on the direction for the county response to health reform. Through the Center for Health Policy and Ethics, Dr. Len Nichols, and Dr. P.J. Maddox served as a consultants to the Task Force. They identified 12 recommendations for the county's consideration. Those recommendations are categorized into six issue areas.

### Issue Areas

- Identification of community needs
- Expansion of services
- Governance
- Information technology
- Enrollment/access/referral
- Payment sources/revenue strategies

Reference the report at:

Public Web: <http://www.regionalprimarycare.org/assets/Final-GMU-Fairfax-County-Report-5-17-12-locked.pdf>

County Intranet: [http://infoweb.fairfaxcounty.gov/HS/DAHS/strategic\\_initiatives/health\\_care\\_reform\\_files/Final%20GMU%20Fairfax%20County%20Report\\_%205-17-12.pdf](http://infoweb.fairfaxcounty.gov/HS/DAHS/strategic_initiatives/health_care_reform_files/Final%20GMU%20Fairfax%20County%20Report_%205-17-12.pdf)

## Process

The Task Force presented the GMU consultant report to 15 boards, authorities, commissions, and advisory groups. Comments are summarized in Appendix II.

In consideration of research on best practices, work in other jurisdictions, implications of federal health reform regulations, and financing, the Task Force identified several issues to further explore. Areas of work into 2013 will cover the following topics:

### Revenue and Resource Development

- Maximize funding to support direct and contracted health care services; and
- Grant application development and program design.

### Service Provision Changes

- Study and respond to the impact of federal health reform—and Virginia’s response—on the Fairfax community health safety net;
  - The Patient Protection and Affordable Care Act expands Medicaid to cover families with incomes up to 138 percent of poverty. States have the option to participate in the Medicaid expansion. Families with incomes above 138 percent but less than 400 percent of poverty will also receive tax credits to help pay for health care coverage in the new health insurance exchanges.
- Identify opportunities to assist individuals (currently without health insurance) to access affordable and quality health care services; and
- Continue review and implementation of best practices for integrated health services: physical, oral, behavioral, specialty care and prescription medication management.

### Infrastructure

- Automate system requirements and adjustment administrative processes for enrollment, screening, and records management to meet the demand for health care services.

### Creation of Health Exchange and Medicaid enrollment

- Estimate and support enrollment and eligibility for health exchange and Medicaid expansion;
- Continue analysis of the Supreme Court ruling upholding key provisions of the federal health care laws and the Commonwealth of Virginia implementation efforts; and
- Assess impact on and partnership opportunities with regional and local safety net partners:
  - Hospitals;
  - Free Clinics;
  - Federally Qualified Health Center providers; and
  - Physicians and care providers in the community.

## Post-Presidential Election—National Trends and Implications for Virginia

In 2011, the U.S. Census Bureau estimated that 48 million Americans, 15.7 percent of the population, did not have health insurance. In Fairfax County, an estimated 130,000 to 144,000 persons currently remain without health insurance.<sup>1</sup> The legislative intent of the passage of the “Affordable Care Act” was to address this gap in access to affordable health care and to create economic incentives for reducing the overall cost of medical care.

The national election results increase the likelihood that the major framework of the Affordable Care Act will remain in place. Two major components in the federal health financing reforms include the establishment of health insurance exchanges and expansion of the federal/state financed Medicaid program. The Congressional Budget Office analysis projects 23 million people will be eligible for participation in health exchanges. Of those, an estimated 18 million will qualify for a federal subsidy based on income. States have the option to operate their own health insurance exchanges or choose federal operation of the exchanges. Virginia has until December 14, 2012 to determine its position on the operation of the exchange. If the state decides against operating its own exchange, it has until mid-February to decide to partner with the federal government or allow for a fully federally-run exchange.

The second component of federal health financing reforms included the expansion of the Medicaid program to cover additional persons. States are in the process of deciding whether to expand their respective Medicaid programs in light of the June 2012 Supreme Court ruling that the expansion authorized under the Act is optional for states.

Beginning January 1, 2014, as many as 430,000 Virginians would gain Medicaid coverage under the new health law. The types of individuals that would be eligible include:

- Low-income adults, with or without dependent children (*examples: Individuals –annual income of less than \$15,302; Family of four – less than \$31,155*);
- Low-income children who currently lose Medicaid benefits when they become 19 years old (*example: children transitioning out of foster care*); and
- Adults with disabilities not eligible for Social Security Supplemental Disability Insurance (SSDI) or Supplemental Security Income (SSI).

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<sup>1</sup> Income, Poverty, and Health Insurance Coverage in the United States: 2011 Current Population Reports  
By Carmen DeNavas-Walt, Bernadette D. Proctor, Jessica C. Smith; Issued September 2012  
<http://www.census.gov/prod/2012pubs/p60-243.pdf>

In Fairfax County, 25,000 to 30,000 individuals are estimated to benefit from Medicaid expansion. Some of these individuals are currently served by the county and new revenue streams to support health services could be realized.

States that opt out of the expansion may leave many of their poorest citizens without the means to obtain insurance in 2014. The PPACA assumed that approximately half of the newly insured Americans would gain coverage through Medicaid, with remaining individuals being served through private market (publicly regulated) health insurance exchanges. As the law is written today, if their household income is less than poverty level, no subsidy for participation in the online marketplaces is provided. If a state decides against implementation of Medicaid, low income residents of that state will have no other option to get insurance under the new law.

If Virginia does not opt for the Medicaid expansion, our county safety net providers, including the Fairfax-Falls Church Community Services Board and the Health Department, will continue to have difficulties meeting the medical, preventive and chronic illness management needs of the uninsured. The burdens of uncompensated care faced by the county and many health care providers in our community will continue to grow. As a result, the pressures of expanding wait lists and efforts to identify and realize new funding streams for critical services, such as substance use treatment and services provided at the Community Health Care Network clinics, will remain unabated. These decisions affect the entire human services system, including those directly provided or contracted, as health and health care access undeniably impact outcomes in areas such as homelessness, academic achievement, and employment.

Advantages to Virginia to participate in Medicaid expansion include:

- Improving access to primary health care, including preventive and acute care, for residents. This helps individuals and small business employers;
- Leveraging resources and services provided by the region's health safety net providers (e.g., Federally Qualified Health Centers, free clinics, hospitals, participating physician groups, and providers accepting Medicaid payment); and
- Providing increased revenue for participating health providers by spreading the cost of care and reducing local "uncompensated care" costs that are absorbed by private and local payment streams, thereby leveraging the existing health provider capacity across the county and region to serve more people or reduce their cost burden.

Nationally, of individuals with health insurance, approximately 55 percent of Americans are covered through an employer sponsored health insurance program/plan, 31 percent have a public insurance plan such as Medicare or Medicaid and 10 percent buy their own health insurance.

To address the growing utilization of Medicaid, federal appropriations were also increased for community health centers including the creation of new “access points.” Increases to primary care physician payment rates under Medicaid were implemented to support the expected growth in newly insured people seeking care. These actions bolstered the utilization of Medicaid in local communities and will benefit Virginia.

Regardless of state financing choices, the Fairfax community needs to direct resources and systems design efforts to create an efficient and effective health safety net service delivery system, taking full advantage of all available state and federal resources, and local community capacity for provision of health care.

The following section outlines the work for system change and specific actions to be taken.

## Vision for Systems Change

***An integrated, effective health care delivery system that provides appropriate and affordable health care for everyone in the Fairfax community.***

*Low income insured and uninsured persons will receive a coordinated, effective, and quality system of care.*

The Task Force's role is to facilitate creation and linkage of community based, cross-disciplinary strategies in support of the systems change goal. To support this work, the Task Force will initiate work on the development of an integrated health safety net system in Fairfax County. This work will be done in collaboration with appropriate private community health providers, community organizations, and advisory boards, authorities, and commissions.

Strategies and actions recommended in this report cannot be implemented effectively without a community-based framework or structure that would enable cross sector and cross agency integration, coordination, and planning.

A new framework will be required to execute the proposed actions and to establish public policy recommendations regarding the allocation and utilization of the county's public investment in the health safety net. The exploration of this framework will be grounded in the vision of creating an integrated safety net system in Fairfax County. Goals to implement the vision are listed in the next page.

“...the most important principles in creating integrated delivery systems for vulnerable populations are: 1) an emphasis on primary care; 2) coordination of all care, including behavioral, social, and public health services; and 3) accountability for population health outcomes.”

*The Commonwealth Fund: “Including Safety-Net Providers in Integrated Delivery Systems: Issues and Options for Policymakers”; August 2012*

## SYSTEM GOAL AREAS

### ❖ Organization Alignment

Align existing services to:

- Maximize service capacity across all health and human services programs; and
- Leverage community services.

To achieve this goal and to maximize the availability, affordability and effectiveness of the health safety net, actions are needed to address:

- Services Integration Efforts;
- Revenue Strategies and Policies;
- Information Technology Supports; and
- Enrollment and Access Business Practices.

### ❖ Leadership and Governance

Develop options on system integration and “governance” of the system.

### ❖ Evaluation and Planning

Assure that county processes stay responsive to the community by enhancing the collaboration with community providers.

Work in support of these goals will involve community capacity building strategies, business process improvements, ongoing communication, leveraging resources and partnerships, workforce development, and legislative and regulatory initiatives.

## Strategies and Work Plan

### Organization Alignment

#### Goal

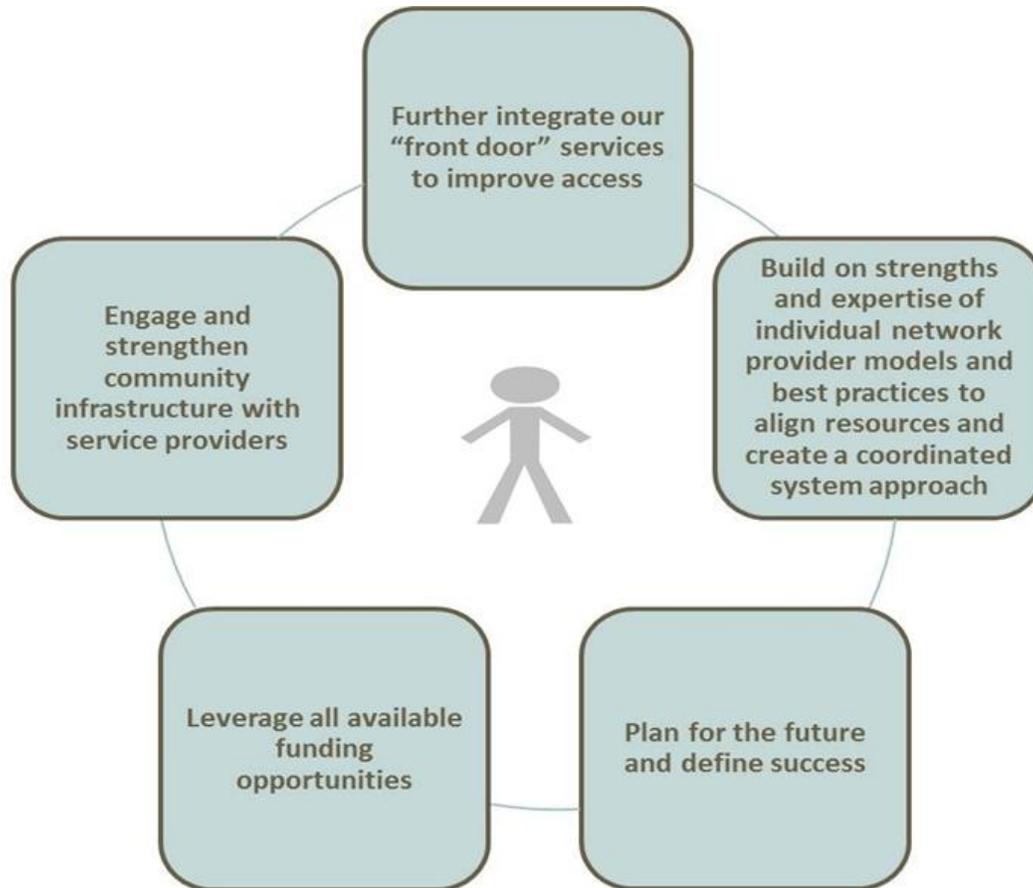
**Create an integrated safety net health care system in partnership with public and private providers.**

On June 7, 2012, Fairfax County received federal designation of a Medically Underserved Area/Population (MUAP) for the south county region through a special Governor's Designation. In June 2012, Loudoun Community Health Center (LCHC) was awarded funding from the United States Health Resources Services Administration (HRSA) for a New Access Point (NAP) facility to provide comprehensive health care services in the western portion of Fairfax County (*Reference July 25, 2012 memo to the BOS, "New Access Point Health Center in Herndon"*). These two significant—and long sought—approvals provide a core and fundamental component to achieve the Task Force's goal to work with the community to develop a fully integrated health safety net.

These efforts:

- Expand current capacity of the health safety net;
- Allow for enhanced federal reimbursement (Medicaid and Medicare) for patients enrolled in Federally Qualified Health Centers (FQHC);
- Provide immediate capacity to serve newly eligible Medicaid and health insurance exchange clients, at a time when there are currently shortages of private sector providers accepting Medicaid as a payment source; and
- Allow service integration for behavioral, oral, primary care services, specialty care, laboratory services, and medication management/dispensing both for site-specific and regional areas of the county, which can improve access for populations where transportation is a significant barrier to care.
- Identify current system best practices that can be expanded or utilized in a different way to maximize availability

### Organization Alignment



The Task Force researched several areas affecting capacity to increase access to quality health care services:

- Geographically, where are services located?
- What types of services are needed?
- How can site co-location best support cross-disciplinary, integrated health services and systems approach to patient care?
- How are services funded to address expected demand?
- What current “health assets” already meet a need that could be leveraged?

To accomplish integration of service delivery, the information gathered by the Task Force will be reviewed to support the following improvement opportunities:

## Service Integration Efforts

**Goal:** Improve quality of care through integration of services with community providers and county provided or funded health services.

### Primary Care Model

**Action:** Support New Access Point (NAP) partners to develop and expand an integrated primary health care system with the support of public and private services in the region. Determine applicability of the pilot as a model for county-wide service strategies.

- Build on strength of network providers for a systems approach;
- Build capacity to leverage existing provider expertise;
- Leverage reduced fee or free services and support, particularly for specialty care services;
- Design, implement and evaluate pilot service delivery model for north county, in partnership with Loudoun FQHC and Jeanie Schmidt Free Clinic, now doing business as Health Works for Northern Virginia, Herndon, and other safety net providers in north county;
- Replicate model for south and mid-county safety net services;
- Establish standards for common electronic health records and data exchange as part of pilot; and
- Utilize interoperable technology for shared clients/mobility between providers as technology is developed. (e.g., Community Access “CAP” system, CommonHelp portal, etc.).

**Lead:** Health Department.

**Resources:** Nonprofit health providers, social service providers, Department of Family Services, Fairfax-Falls Church Community Services Board, Inova Health System.

### Dental Care

**Action:** Develop an integrated dental care model to improve access to local dental service programs for more adults by working with safety net and community providers.

The current county investment in oral health programs does not meet current need. A team with public, private and non-profit representatives has been established to integrate oral health safety net services to:

- Address access and waiting list issues for Fairfax County residents;
- Develop a strategy to engage private oral health practitioners in this effort;
- Propose a plan for consolidation and/or centralization of intake screening;
- Establish common and consistent appointment scheduling processes for all public health and community safety net dental services; and

- Identify appropriate metrics so that tracking of oral health issues and outcomes are possible.

**Lead:** Northern Virginia Health Foundation, Health Department.

**Resources:** Department of Family Services, Department of Administration for Human Services, Northern Virginia Dental Clinic, Northern Virginia Family Service, Department of Neighborhood and Community Services.

### Access to Care

**Action:** **Develop “front door” and access strategies to increase collaboration among providers of health safety net services.**

- Utilize community enrollment and eligibility systems for common data sharing;
- Standardize client confidentiality protocols and systems; and
- Develop uniform, system-wide client outcomes and measures.

**Lead:** Department of Family Services, Fairfax-Falls Church Community Services Board.

**Resources:** Federally Qualified Health Centers; Department of Neighborhood Community Services, Coordinated Services Planning; Department of Family Services, Health Access Assistance Team (HAAT) and Adult and Aging Services; Health Department, Long Term Care Coordinating Council; Fairfax-Falls Church Community Services Board, FAST team; nonprofits funded by county to support program and eligibility determination.

### Pharmacy Management

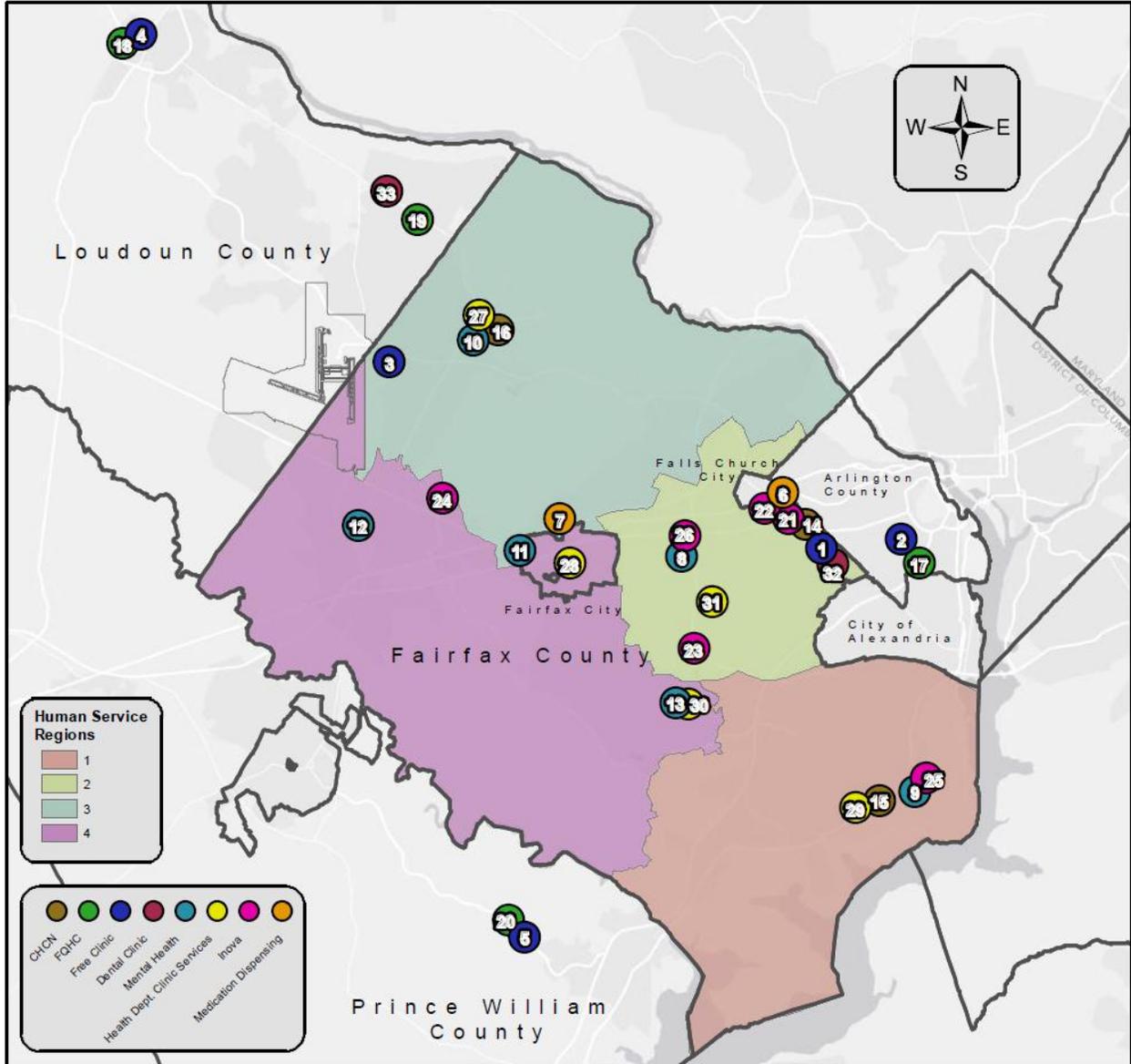
**Action:** **Align county investment in patient assistance programs that help low-income, uninsured individuals to maximize availability and accessibility.**

- Share and integrate data to ensure accountability and transparency;
- Assess current program capacity for redundancy; overhead/administration costs; gaps and needs; and
- Establish measures and outcomes.

**Lead:** Fairfax County Health Department, Department of Neighborhood and Community Services.

**Resources:** Northern Virginia Family Service, NOVA ScriptsCentral, Fairfax-Falls Church Community Services Board, VICAP coordinator, Department of Neighborhood and Community Services’ Coordinated Services Planning, community and faith based organizations that provide pharmaceutical assistance.

Current Services and Locations of Key Health Safety Providers



1) Culmore Clinic 3245 Glen Carlyn Road Falls Church, VA 22041	8) Woodburn Center 3340 Woodburn Road Annandale, VA 22003	14) CHCN - Bailey's 6196 Arlington Blvd Falls Church, VA 22044	21) InovaCares Clinic for Women 6400 Arlington Blvd Falls Church, VA 22042	27) Hemdon-Reston District Office 1850 Cemeron Glen Drive Reston, VA 20190
2) Arlington Free Clinic 2921 11th Street South Arlington, VA 22204	9) Gartlan Center 8199 Holland Road Alexandria, VA 22306	15) CHCN - South County 8350 Richmond Highway Alexandria, VA 22309	22) InovaCares Clinic for Children 6400 Arlington Blvd Falls Church, VA 22042	28) Joseph Willard Health Center 3750 Old Lee Highway Fairfax, VA 22030
3) HealthWorks - Herndon 13525 Dulles Technology Drive Herndon, VA 20171	10) Reston - Northwest Center 1850 Cameron Glen Drive Reston, VA 20190	16) CHCN - North County (Lake Anne) 11484 Washington Plaza West Reston, VA 20190	23) Inova Juniper Program 8004 Forbes Place Springfield, VA 22151	29) Mount Vernon District Office 8350 Richmond Highway Alexandria, VA 22039
4) HealthWorks - Loudoun 224 Cornwall Street Northwest Leesburg, VA 20176	11) Assessment & Referral Center 3900 Jermantown Road Fairfax, VA 22030	17) Arlandria Health Center (ANHS) 2445 Army Navy Drive Arlington, VA 22206	24) Inova - Fair Oaks 3600 Joseph Sjewick Drive Fairfax, VA 22033	30) Springfield District Office 8136 Old Keene Mill Road Springfield, VA 22152
5) Prince William Area Free Clinic 4001 Prince William Parkway Woodbridge, VA 22192	12) Chantilly Office 14150 Parkeast Circle Chantilly, VA 20151	18) Loudoun Community Health Center 224 Cornwall Street, NW Leesburg, VA 20175	25) Inova - Mt. Vernon 2501 Parker's Lane Alexandria, VA 22036	31) Annandale District Office 7611 Little River Turnpike Annandale, VA 22003
6) NOVA ScriptsCentral 6400 Arlington Blvd Falls Church, VA 22042	13) Springfield Office 8348 Traford Lane Springfield, VA 20152	19) Health Center for Children and Families 46440 Benedict Drive Sterling, VA 20164	26) Inova - Fairfax 3300 Gallows Road Falls Church, VA 22042	32) Northern VA Dental Clinic 5827 Columbia Pike Falls Church, VA 22041
7) NVFS-Fairfax Accessible Medication Program 10455 White Granite Drive Oakton, VA 22124	20) Greater Prince William Community Health Center 4379 Ridgewood Center Drive Woodbridge, VA 22192			33) Northern VA Dental Clinic 2 Pidgeon Hill Drive Sterling, VA 20165

## Revenue Strategies and Policies

**Goal:** Create an environment in which the community responds collectively to the need of uncompensated/undercompensated care and the burden is spread more equitably across health providers—both private and public—that are serving the community.

With full implementation of a new health insurance exchange at the state level and expansion of Medicaid to the fullest extent allowed through federal incentives for coverage, an estimated 430,000 Virginians will be new to the health insurance market. In Fairfax County, 25,000 to 30,000 additional individuals will be newly eligible for Medicaid and 30,000 to 40,000 individuals could receive subsidies under a Virginia Health Insurance Exchange. The array of authorized services and levels of care to be covered by Medicaid and the health insurance exchange, as well as the payment rates for provision of health care, will impact individuals' ability to receive needed health care.

Both volume and price will determine the market incentive for private medical providers to participate in the health exchange and Medicaid. The attractiveness for participation is influenced by:

- Individual requirements to participate in insurance plans—including Medicaid;
- Partnerships with regional specialty care providers;
- Willingness—and ability—of hospitals and medical providers to accept payment levels offered through Medicaid, Medicare, and the health insurance exchanges; and
- Ability to leverage ongoing relationships with insurers participating in the exchanges on payment schedules/rates for their client base.

Each of these considerations will influence medical providers' business decisions to participate in Medicaid and the health exchanges. The County must position itself, like any other health provider, to assure that the public system capacity is sufficient and that financing for health services is diversified and covers costs of care.

The Task Force makes the following assumptions:

- No one sector is responsible for the entire cost of providing this care—it is a shared responsibility;
- With full implementation of the tools available through the Affordable Care Act (enroll new participants in Medicaid and the insurance products in the health exchange), by leveraging cost sharing from participating individuals and more systemic approaches to provision of charity or reduced fee care, the cost of uncompensated/undercompensated care can be spread between provider entities in a more equitable way;

- The overall health care cost burden can be reduced through enrollment of insured populations into health insurance programs to address preventable and otherwise more costly health issues left untreated;
- Many private providers will be willing to “share the burden” of the cost of care for the underinsured, uninsured or for individuals with limited income and who qualify for federal and state funding supports for health care.

Considerations:

- Resources provided through federal action could eventually be substantial; and
- Virginia choices regarding utilization of new Medicaid funds affect the community:
  - Payment rates to providers must be adequate for successful integration of services; and
  - Newly eligible beneficiaries may experience difficulties finding private providers accepting Medicaid payment rates for health services.

To support a community-wide effort to improve the health safety net in the community, the Task Force recognizes the need for ongoing data collection and monitoring of community-wide capacity to:

- Assure effective, efficient services;
- Minimize public funding investment where alternative funding is provided; and
- Assure maximum capacity for health care to vulnerable populations—including clients traditionally served in the public system—persons with serious mental illness, persons with chronic disease management concerns, and persons experiencing poor health outcomes due to barriers in accessing treatment.

**Action:** **Develop a long-range plan for safety net service provision to incorporate a mix of funding sources, including insurance coverage expansion under the Affordable Care Act.**

Continue monitoring the capacity of the safety net, the county’s investment, and work collaboratively with the health provider community to:

- Assure that all providers have an array of available funding sources;
- Ensure that providers are not dependent upon one financing strategy; and
- Access an appropriate mix of funding to assure quality and stable organizational capacity.

**Lead:** Health Care Reform Implementation Task Force (to be renamed: “Fairfax Community Health Collaborative”).

**Resources:** To be determined.

**Action:** **Review payment practices and array of payer sources including Medicaid, Medicare, and private insurance, especially in preparation for expansion of health care insurance coverage in 2014.**

For the county to take advantage of funding available through the state established Health Insurance Exchange and Medicaid expansion, considerations include:

- Current shortage of private primary care providers throughout Northern Virginia—not enough health providers are currently accepting Medicaid to meet expected demand;
- Support to existing community providers accepting Medicaid to gear up to respond to the expanded eligible population seeking health care;
- Leverage additional health access points operated by the FQHCs to support the demand for medical services; and
- Application development for new discretionary federal funds to address community service gaps.

Feedback from some members of county boards, authorities, commissions, and advisory groups included concern on public policy decisions affecting health care delivery:

- Should county provided health care services be funded through Medicaid? What are the administrative and infrastructure requirements to participate?
- Would county participation “crowd out” other individuals needing health care?
- How can the county leverage its existing service capacity to complement the private market and the nonprofit health providers

**Lead:** Health Department, Fairfax-Falls Church Community Services Board.

### Information Technology Supports

**Goal:** **Invest in uniform and integrated information technology that supports a comprehensive and coordinated array of clinical care and administrative functions across all county health and human services agencies and programs.**

The Fairfax County Human Services Information Technology plan was completed in July 2012. Components of the plan directly address integration of data systems and supports for the health safety net. Objectives include:

- Enable online collaboration and information dissemination by staff and service providers;
- Facilitate staff and client mobility with appropriate technologies;
- Provide secure methods for reporting and sharing of accurate data and information amongst staff and service providers;

- Share technology costs by acquiring, developing, and implementing Fairfax County Human Services system-wide solutions where feasible; and
- Cultivate public/private partnerships to defray software and infrastructure expenses.

### **Current Health Safety Net Related Internal Data Systems in Production or Design**

#### **Department of Family Services**

Development of a new streamlined customer application process for public assistance and child care utilizing the state's new customer portal, Common Help.

#### **Fairfax-Falls Church Community Services Board**

1. Electronic Health Record (EHR); supporting behavioral health clinical and business practices.
2. Requirements and design activities to meet new requirements for:
  - Email encryption with state and contract/private behavioral health partners;
  - Development of a data exchange funded by the Kaiser Foundation for a Health Information Exchange (HIE) between the Fairfax-Falls Church Community Services Board (CSB) and providers. Components of the model will include hardware solutions to facilitate input of medical and clinical information for CSB behavioral health services; and
  - Data exchange system between CSB behavioral health electronic health records and private provider laboratory services to comply with HIPAA requirement for secure transactions as part of the automation of client health records.

#### **Health Department**

1. Electronic Health Record (EHR) to support primary health clinical and business practices.

The Task Force recognizes the importance of leveraging the Commonwealth of Virginia's strategies, which finance and support a comprehensive and integrated human services system for the following reasons:

- Many locally provided health systems services and related supports are overseen by state agencies and are partially state and federally funded. It is critical that the county participate in the state's analysis of requirements definition and design

activities to obtain technology solutions that support local health services delivery;

- Interoperability between state financed reporting systems and local health care service delivery will ensure the best use of available federal and state financing;
- The cost of information technology systems design cannot be borne by the county alone;
- Local health information technology systems for eligibility, client intake, provision of medical care, ancillary supports (laboratory, pharmacy management), and individual client electronic health records need to be continually assessed and monitored to ensure interoperability over time as state capacity for full integration occurs. **The current systems will continue to be used at the local level and phased out as new alternatives for comprehensive technology solutions are available. Partnerships with community providers, county business users, information technology experts are needed for coordination of public policy decisions;**
- New initiatives, including those integrating uniform assessment instruments for services provided for adults through Virginia's Department of Aging and Rehabilitative Services and Department of Social Services, as well as through local partners including county departments and Inova Health System;
- Ongoing initiatives to partner with local nonprofit provider network and information and referral services; and
- New technologies such as scanning, mobile devices, and tele-medicine supports will be integrated and leveraged to reduce costs, improve efficiencies, and streamline client health care.

**Action:** **Expand the use of the existing streamlined eligibility system and support current efforts to expedite utilization of the new cross-program integrated eligibility system the Virginia Health and Human Resources secretariat is currently developing. Continue to monitor state-wide efforts for systems development and design.**

In July 2012, Virginia implemented a new online screening and application system for residents to access public assistance programs known as CommonHelp. Applications for Medicaid, Supplemental Assistance Program (SNAP), and child care programs are currently processed through this online system. CommonHelp will be enhanced in the coming year to include the new Medicaid Child Health Insurance Program (CHIP) rules mandated by the PPACA. State officials intend to use CommonHelp as an interface to the new health exchange that will be operational by January 2014.

In anticipation that CommonHelp will be a tool to allow for expedited enrollment in Medicaid and the health exchange, Fairfax County took an active role in promoting its use and presence in the community.

In September 2012, approximately 48 percent of all applications for public assistance state-wide were generated through CommonHelp (CH); of those, approximately 80 percent of all CH applications received by the state were associated with residents of Fairfax County and the cities of Falls Church and Fairfax.

**Lead:** Department of Family Services.

**Resources:** Human Services Strategic Information Technology (IT) planning group.

**Action:** **Develop tools for online collaboration and information dissemination by staff and service providers:**

- Facilitate staff and client mobility with appropriate technologies;
- Provide secure methods for reporting and sharing of accurate data and information amongst staff and service providers;
- Share technology costs by acquiring, developing, and implementing FCHS system-wide solutions where feasible; and
- Cultivate public/private partnerships to defray software and infrastructure expenses.

**Lead:** Fairfax Community Health Collaborative.

**Resources:** Human Services Strategic Information Technology (IT) planning group and Department of Information Technology.

### **Enrollment and Access Business Practice Strategies**

**Goal:** **Develop common data exchange of information protocols.**

**Action:** **Monitor development of Commonwealth of Virginia HHR Memorandum of Understanding on data exchange opportunities between state programs and services.**

**Action:** **Develop implementation strategy for local use across health systems and support programs and services:**

- Research rules and regulations;
- Benchmark jurisdictions;
- Develop standards for electronic information exchange;
- Develop common client consent protocols; and
- Incorporate HIPAA, Privacy Act, and related laws and regulations.

**Lead:** Department of Family Services.

**Resources:** Fairfax County Inter-governmental Relations Office; County Attorney; Human Services Information Technology Planning team (Fairfax-Fall Church Community Services Board, Health Department, Department of Neighborhood and Community Services, Department of Administration for Human Services representatives); County HIPAA Coordinator; program staff representatives from the Health Department, Family Services and Federally Qualified Health Centers.

**Action:** **Establish integrated business practices and infrastructure tools for screening, eligibility and enrollment systems.**

County funded health safety net services share common clients; to minimize administrative costs and maximize the use of county taxpayer funds for health care services, steps should be taken to incorporate standards to limit administrative overhead and maintenance through integrated business practices and infrastructure tools.

Steps to include:

- Agreement to utilize community enrollment and eligibility systems for common data sharing;
- Agreement to utilize standard client confidentiality protocols and systems;
- Development and utilization of uniform, system-wide client outcomes and measures; and
- Utilization of interoperable electronic health records for shared clients/mobility between providers as technology is developed.

The Task Force recognizes the importance of leveraging the available resources and supports developed and supported by the Commonwealth of Virginia in strategies which maximize system responses to provision of quality client health care. An example is the utilization of a state-wide confidentiality MOU process for sharing of client information across state departments. This model can be replicated for use at the local level.

**Lead:** Department of Family Services.

**Resources:** To be determined.

**Action:** Conduct an outreach campaign in late 2013 to inform the community of the new insurance coverage options and Medicaid expansion available as of January 2014. In cooperation with both public and private partners, develop outreach and education efforts that target the Fairfax business community and individuals who most directly benefit from tax credits and subsidies to help their employees gain health coverage.

Activities to support outreach efforts to individuals in need include:

- Outreach efforts to small businesses, self-employed individuals, and the public to advertise the new health exchange and tax credit advantages for participation. Activities will be coordinated with the Fairfax County Small Business Commission, the Economic Development Authority, and Department of Tax Administration.

**Lead:** Fairfax County Human Services Communications Workgroup.

**Resources:** To be determined.

As noted in the consultant study, in Fairfax County 25,000 to 30,000 individuals are estimated as eligible for the Medicaid expansion and 30,000 to 40,000 individuals eligible to participate in the health exchange, when both are operational in January 2014. Awareness of their new eligibility status will be important to the community to decrease the number of uninsured.

Reaching, informing, and assisting eligible individuals in an effort to enroll them in these support services will reduce the public cost of health care for all sectors of the safety net currently serving these individuals without compensation. Similar to efforts for previous program expansions for health services that benefited low income children and families in the county during the early 1990s, the county will benefit from a coordinated community effort to find all newly eligible individuals to enroll them. For individuals, the benefits of receiving care have been demonstrated to save lives and reduce overall community costs for care.<sup>2</sup>

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<sup>2</sup> See “Mortality and Access to Care among Adults after State Medicaid Expansions”; Benjamin D. Sommers, M.D., Ph.D., Katherine Baicker, Ph.D., and Arnold M. Epstein, M.D.; Harvard School of Public Health, *The New England Journal of Medicine*, July 25, 2012. This report compared three states (New York, Arizona and Maine) that had already expanded coverage of childless or disabled adults with four neighboring states (Pennsylvania, New Mexico, Nevada and New Hampshire) that had not. Deaths among people ages 20 to 64 dropped in the three expansion states by about 1,500 a year, adjusted for population growth, whereas death rates in the comparison states went up. Expansion also brought a 21 percent reduction in cost-related delays in getting care.

## Leadership and Governance Options

**Goal:** **Implementation of an integrated health safety net system in Fairfax County, in collaboration with private community health providers, community organizations, and advisory boards, authorities, and commissions.**

Achieving this goal will assure maximum capacity for health care to vulnerable populations including clients who are traditionally served in the public system. These include individuals with serious mental illness, persons with chronic disease management concerns, and others who experience disparate health outcomes due to barriers in accessing health care. Preventive care, treatment, and after-care support services are needed to assure effective service delivery for maximum client benefit. Through comprehensive approaches with improved cost effective outcomes, system-wide costs can be reduced.

**Action:** **Develop options on system integration and governance of the safety net service delivery system.**

- Work to include hiring systems integration consultant for the following activities:
  - Complete assessment and gap analysis of currently provided services;
  - Develop options for a governance model; and
  - Make recommendations on ongoing data collection and monitoring of community-wide capacity to assure effective, efficient services and to minimize public funding investment where alternative funding is available.

Focus of leadership/governance recommendations will be on:

- Decision-making process for operations and funding controlled by participating representatives;
- Defined agreement on who is served and how they are served in the “health safety net;”
- Identification of:
  - Funding and resource allocation/leveraging opportunities within existing infrastructure;
  - Areas that require community solutions to address known gaps in services and outcomes; and

- Community discussion on outcomes and accountability for an integrated health system in the Fairfax community.
- Description of anticipated enrollment related workload associated with new health services products and expanded/changing services:
  - How individual participants will be tracked/supported as their income and eligibility fluctuates;
  - Documentation of enrollment and health data exchanges;
  - Electronic health records interfaces and state systems;
  - Connections to safety net providers (hospitals, FQHCs, local government, CBOs);
  - Recommendations on any realignment of services to fill the gaps, including the identification of:
    - available funding/financing, grants and sources to support services;
    - additional costs to the county and sources of funding;
    - sustainability of financing—models for consideration/advocacy.
  - Articulation of the public sector role in health “safety net;” and
  - Analysis of impact to the community on anticipated community practice changes.

**Lead:** Fairfax Community Health Collaborative.

### Evaluation and Planning

**Goal:** Improve community capacity to identify and address unmet health needs of low income individuals and others who experience disparities in health access, care, and good health outcomes.

**Action:** Engage community in identification of health services priorities through work of the Partnership for Healthier Fairfax and the Community Transformation Grant.

**Action:** Work with Inova Health System to address the unmet needs identified in the Inova Community Health Needs Assessment (CHNA).

**Action:** Monitor priorities for specific community needs, particularly behavioral health and dental services where current gaps in services exist.

**Action:** Develop regular communication strategies to obtain community input into community planning and advocacy activities.

**Lead:** Health Department.

**Resources:** Community partners, Inova Health System, Reston Hospital.

The Task Force recognizes the importance of creating an entire system of comprehensive, integrated community health services and will seek regular engagement and collaboration with the community to identify solutions to gaps in health safety net services.

Public policy choices affecting county funded service delivery; options for provision of care; and priorities for use of local, state, federal, and client generated funds incorporated into the county's services will be impacted by the long term planning and identification of needs. To best inform the Board of Supervisors on choices affecting the public funding, regular communication and collaboration on priorities is necessary.

Community partners have both a role and an investment in community needs identification and planning. One significant partner includes Inova Health System, which has a long standing practice of collaborative efforts with the county on both program and operational levels. As part of its implementation of the Affordable Care Act, Inova is required by federal law to base its review of community needs by individual hospitals within its system. Quality Councils that are hospital-based will participate in the development and assessment of the data collected through the CHNA.

The most important aspect of the CHNA and other planning/gap and community assessment efforts is the creation of a community action plan to address identified needs. The county's health systems planning activities will be informed by the CHNA, and in turn, the county's work through the Partnership for a Healthier Fairfax and Community Transformation Grant will reciprocate to inform the CHNA community planning activities.

**Action:** **Develop an evaluation program for the health safety net system.**

**Lead:** Health Department.

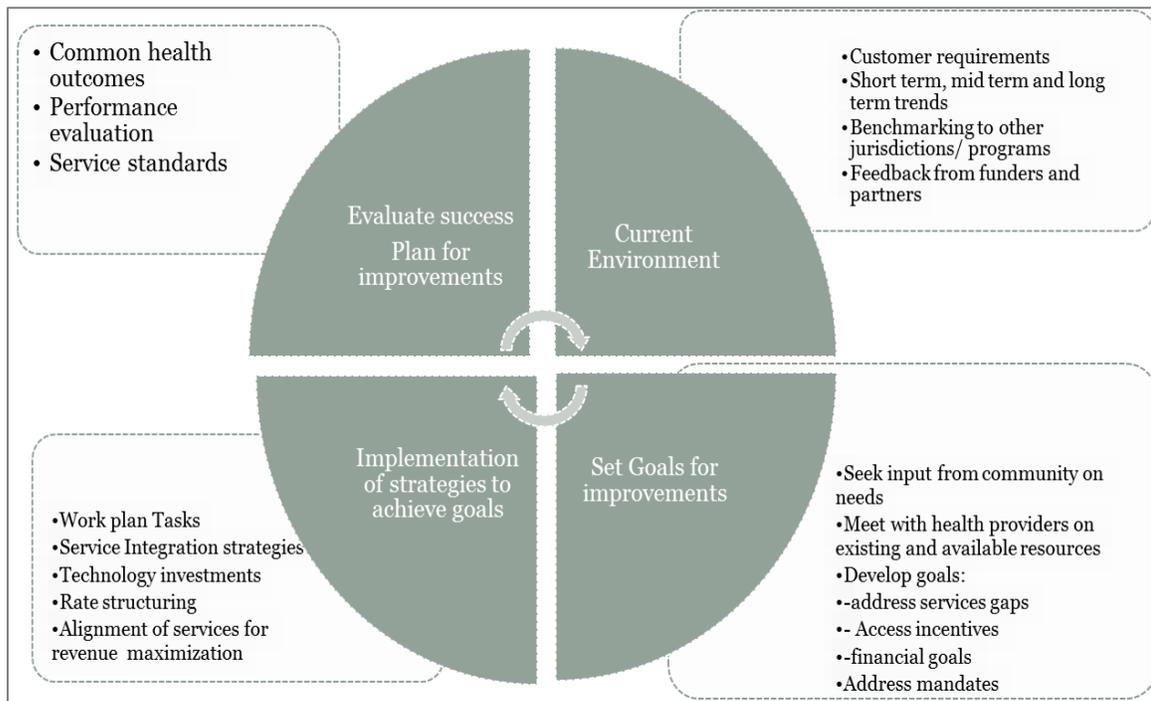
**Resources:** Inova Health System, Partnership for a Healthier Fairfax, Fairfax-Falls Church Community Services Board.

## Summary

### Proposed tasks for Phase II work – support for “Fairfax Community Health Collaborative”

Continue support for the integration of services (primary, behavioral health, oral):

- Refine and update the Task Force’s inventory of “health assets;”
- Recommend areas to address gaps in anticipation of creation of health exchange in Virginia and a second scenario if components of health reform are found unconstitutional;
- Provide to the Board of Supervisors recommendations on general assembly actions, the governor’s regulatory actions for Medicaid, managed care initiatives impacting Northern Virginia, support for—or actions—in relation to localities and participation in provision of direct care services;
- Review of relationship among funded providers with governance structure of county-run programs;
- Define linkage to ongoing implementation and planning related to the safety net and governance options;
- Identify advocacy issues for county local government in relation to state implementation on health care financing reform or direct service provision for the health safety net;
- Oversee action teams identified in report; and
- Report on progress to Fairfax County leadership on quarterly basis.



# Attaining Our 2015 Goals

<p><b>Vision</b></p> <p>An integrated, effective health care delivery system that provides appropriate and affordable health care for everyone in the Fairfax community.</p>	<p><b>Core Goal Areas</b></p> <p>Public/Community Safety Net Service Integration</p>	<p><b>Critical Work</b></p> <ol style="list-style-type: none"> <li>Working with northern Virginia Federally Qualified Health Centers, create access and service delivery processes to support full service integration.</li> <li>Evaluate and enhance processes to maximize access to oral, prescription and pharmacy, specialty, public health, behavioral and primary health care.</li> <li>Establish front door access process.</li> <li>Assure cultural competency in all aspects of service delivery.</li> </ol>
<p><b>Guiding Principles</b></p> <ul style="list-style-type: none"> <li>Support Individual Responsibility</li> <li>Seek System Integration/Optimization</li> <li>Pursue Sustainable System Financing</li> <li>Ensure Accountability, Transparency, and Improvement</li> <li>Pursue Advocacy and Stewardship Consistent with County's Mission</li> </ul>	<p><b>Revenue Strategies and Policies</b></p>	<ol style="list-style-type: none"> <li>Develop and maintain long-term financial plans and sustained funding in relation to:             <ul style="list-style-type: none"> <li>Health Insurance Exchange</li> <li>Medicaid expansion</li> <li>Navigation of individuals to right plans</li> </ul> </li> <li>Advise the Board of Supervisors on appropriate policies and investment strategies.</li> </ol>
	<p><b>Information Management and Data Sharing</b></p>	<ol style="list-style-type: none"> <li>Expedite utilization of the new cross-program integrated eligibility system.</li> <li>Develop tools for online collaboration and information dissemination by staff and service providers.</li> <li>Develop common data exchange of information protocols.</li> <li>Establish integrated business practices and infrastructure tools for screening, eligibility and enrollment systems.</li> </ol>
	<p><b>Leadership &amp; Stewardship</b></p>	<ol style="list-style-type: none"> <li>Develop options on system integration.</li> <li>Creation of a broader health safety net "Health Integration Council" to establish agreed-upon performance targets.</li> <li>Develop strategies to address community-wide disparities.</li> </ol>
	<p><b>Evaluation and Planning</b></p>	<ol style="list-style-type: none"> <li>Implement a continuous process improvement system incorporating customer care quality and outcomes.</li> <li>Establish benchmarks for performance and standards-driven service delivery based on national standards.</li> </ol>

## Appendix I: Fairfax County: Health Care Reform Task Force – FY 2010-2011 Charter

### **Background:**

In March 2010, Congress passed and the President signed into law the Patient Protection and Affordable Care Act. This act incorporated comprehensive health insurance reforms, with the goals of establishing more accountability into the system, lower health care costs, improve consumer health care choices, and increase the quality of health care nation-wide. Specific provisions included establishment of competitive private health insurance markets through state exchanges, reforms on eligibility related to pre-existing health conditions, and added coverage options for access to affordable health care for individuals, families, seniors, and businesses. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

### **Purpose of the Health Care Reform Implementation Task Force:**

The Health Care Reform Task Force is established to develop a community and Fairfax County government response to requirements of federal Health Care Reform. It shall:

- Study the provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, and analyze the operational impact of the various requirements;
- Recommend strategies for implementation, to include policy decisions related to future structuring of safety net services, incorporating analysis of existing, revised and new health insurance coverage opportunities; and
- Implement and operate approved and agreed upon actions.

### **Actions:**

#### ***The Health Reform Task Force will:***

- Conduct a thorough study of the potential impact of federal and state health care reform policies, legislation and regulatory acts on Fairfax County (and residents of Fairfax and Falls Church served by the county), to include:
  - Review of the potential community impact of increased enrollments resulting from potential expanded eligibility for Medicaid and other subsidized health insurance instruments;
  - Examination of possible strategies to address anticipated community-wide shortages in primary and specialty care, particularly in relation to provision of culturally competent and linguistically accessible care;
  - Recommendations for provision of safety net services which incorporate best practices for improving community health through prevention and wellness strategies;
  - Potential benefits to the community of Medicaid/Medicare insurance reforms;

- Requirements which shall address timely implementation of any mandates and/or reforms which maximize system capacity for service provision;
- Identification of any possible revenue opportunities that may enhance the Fairfax safety net system, such as available health grants for expanded or new health services, information technology (electronic medical records; integration of systems) and training;
- Completion of an analysis of health care reform implications for Fairfax County's safety net system network, including review and capacity of the Community Health Care Network, Federally Qualified Health Centers and other health care organizations as community health centers;
- Alignment of taskforce recommendations with acute services study for persons receiving behavioral health care services;
- Participation in regional planning, policy development and operations plans as required;
- Monitoring work of the Commonwealth of Virginia's Task Force on Health Care Reform;
- Maintaining regular communications to obtain input and feedback from affected boards, authorities, and commissions, including the Fairfax County Health Care Advisory Board, the Fairfax-Falls Church Community Services Board and others as required; and
- Utilize staff resources as needed.

### **Task Force deliverables:**

Prepare and submit to the Board of Supervisors policy recommendations that highlight a communication plan and implementation strategy on key actions and decisions that must be taken in the immediate, short and long term to educate and optimize the delivery of the key elements of health care reform in the Fairfax community:

- Prepare recommendations for provision of safety net services for health care reform implementation efforts, incorporating best practices, performance measures and a communication plan;
- Prepare and submit to the Board of Supervisors a community plan to educate, inform, and make policy recommendations on implementation strategies for health care reform in the Fairfax community.

### **Membership:**

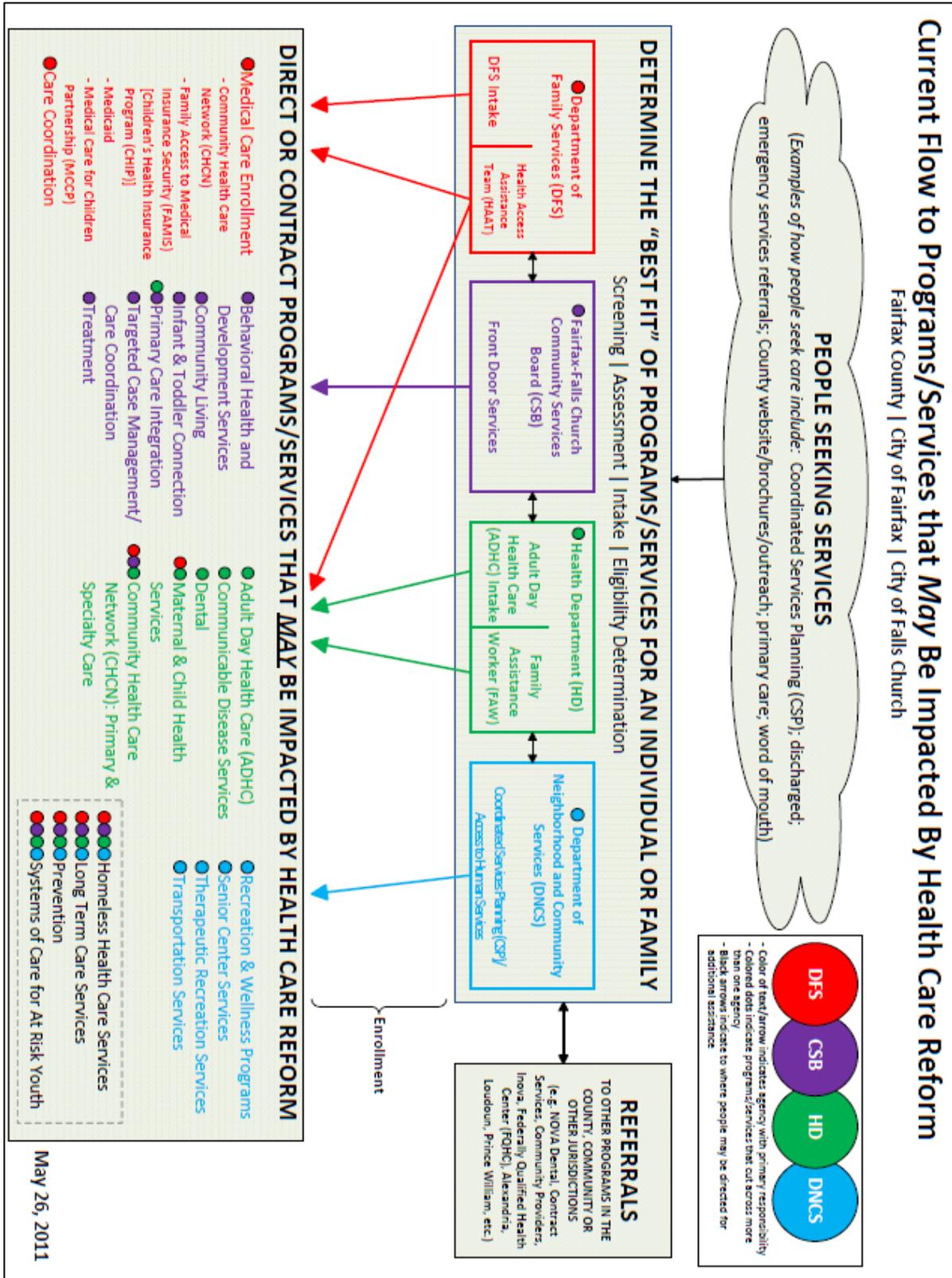
- Representatives from key services areas impacted – physical health, behavioral health, social services, and the community
- Individuals with technical expertise and/or consultant experience with direct services in Fairfax County
- Representatives from key boards, authorities, and commissions

## Appendix II: Principles for Discussion on Health Care Reform Implementation

*Adopted April 2011*

- ◆ The alignment of the existing health care system must change
- ◆ An integrated health care delivery system includes appropriate and affordable health care for all persons
- ◆ The county should strive to create an integrated network for primary, behavioral and oral health care in partnership with community providers
- ◆ The county should promote a culture that supports each person to be responsible for his/her own health
- ◆ Community health outcomes should incorporate....
  - How well we do ....what is working and what is not
  - Health impact assessment of services provided by the county departments and programs
- ◆ Analyze and address identified health disparities for specific populations
- ◆ Low income insured and uninsured persons should receive a coordinated, quality system of care with a medical home
- ◆ The county should not be in the business of providing resources available to the broader community
- ◆ The county should provide information and assistance to low income individuals to access appropriate health resources and supports, including information on what is available and what they eligible for
- ◆ The created system should not be designed on assumption that low income persons lack resources to address their health care needs
- ◆ The county should facilitate creation/linkage of the right mix of resources and services provision through both “active and passive” community partners
- ◆ The county should not presume to fill all health services/support gaps with public services
- ◆ Preventive services are needed to achieve \$ savings in the long term for the entire system
- ◆ Focus should be on better management of existing resources and models that do least harm given fiscal constraints
- ◆ Fairfax community should advocate for policies in the commonwealth that support the needs of our residents

## Appendix III: Current Health Services System and Access to Existing Safety Net Services



## Appendix IV: Task Force Accomplishments

### Analysis of Health Care Reform laws

- ◆ Identification of known gaps in Fairfax County safety net
- ◆ Comparisons to other systems and recommendations for effective models for creation of an integrated system of care
  - Analysis of managed care and potential partnership opportunities for low income, older adults, persons with chronic conditions, serious mental illness, etc.
  - Creation of medical home models – using primary provider/referral systems or network of linked providers in “managed care” settings.
- ◆ Analysis of possible choices/scenarios based on Commonwealth of Virginia action steps, including:
  - Impact of various managed care scenarios to local residents and the Fairfax network
  - Analysis of Medicaid and factors in both service availability, capacity and reimbursement
  - Study of health care exchanges and opportunities for Fairfax community
  - Analysis of available Medicaid waiver opportunities and possible advocacy recommendations for Commonwealth participation for long term care, persons with mental illness and individuals with physical or intellectual disabilities.
  - Accountable care organizations, structure and possible relationships/partnerships/contractual service options.
  - Analysis of data exchange/electronic data needs and state plans for health insurance exchange data design.
  - Review of state actions on medical provider payment reform and monitoring State Corporation Commission regulations regarding insurance.

### Data Collection and Environmental Scan Activities

- ◆ Inventory of existing “health assets” in the community, including county programs and services, eligibility and needs.
- ◆ Analysis of current resources for long-term care and county relationship/financing of services and facilities, including regional services and county managed assisted living facilities.
- ◆ Identification of available community and public sector primary and preventive services.
- ◆ Conversations and planning with private providers on business models being developed by community providers.

### Evaluation

1. Documentation of potential changes/service delivery impact resulting from affordable care act implementation.
2. Documentation and analysis of uncompensated care populations.

## Appendix V: Summary of Boards, Authorities, and Commissions Input on George Mason University Consultant Report

GMU Recommendation	ASSB (3/27/12)	COA (5/16/12)	CAC (5/16/12)	CAAB (4/3/12)	CSB (3/28/12)	Commission for Women (7/9/12)	DSB (5/12/12)	HCAB (4/9/12)	NOVA Access to Health Care Consortium (4/26/12)	LTCCC Med & Soc Services Committee (3/20/12)	MCCP (5/18/12)
<p><b>Rec #1:</b> Work collaboratively with INOVA to develop the first Community Health Needs Assessment (CHNA) required by PPACA to help identify priorities and solutions for population health improvement.</p>	<p>Look for way to integrate MAPP/CHNA process</p>	<p>While there are leverage opportunities with INOVA – where do we even begin? PACE opened the door to conversation to partner, but incentives are needed.</p> <p>Would like to see INOVA take on more home care services.</p>	<p>BOS should request regional planning groups in the community review process.</p> <p>Ensure equitable support from Inova – regionally.</p> <p>Pat (Harrison) should make a phone call to Knox and ask their plans.</p> <p>County missed an opportunity.</p>	<p>Find ways to integrate MAPP and CHNA for best use of community resources and planning efforts;</p> <p>Would like to see more accountability from Inova</p>	<p>It would make the tool and results too Inova-centric</p> <p>Other hospital and health care systems such as HCA would be left out</p>		<p>Do we know if DSB was represented in the Needs Assessment? Was physical barriers addressed?</p> <p>Lack of DSB representation in PFHF process.</p>	<p>We should not assume Inova’s assessment will represent the entire community.</p> <p>Consider finding ways to collaborate our MAPP efforts to strengthen their assessment to ensure minimal gaps</p> <p>We have not included INOVA in any of our deliberations; missed an opportunity to include them in our planning phase.</p> <p>Inova was represented in the MAPP process, but we were not truly collaborative with them in the Task Force.</p> <p>It’s not too late to strengthen the Inova relationship now in the CHNA process</p> <p>HCAB is not in a position to talk to Inova or consultant.</p>			<p>Feels there is an issue with communicating the county’s needs out to the community. The county should hire a firm – to create messaging on how you can help meet the needs of the poor in Fairfax.</p>

# ACTION PLAN

GMU Recommendation	ASSB (3/27/12)	COA (5/16/12)	CAC (5/16/12)	CAAB (4/3/12)	CSB (3/28/12)	Commission for Women (7/9/12)	DSB (5/12/12)	HCAB (4/9/12)	NOVA Access to Health Care Consortium (4/26/12)	LTCCC Med & Soc Services Committee (3/20/12)	MCCP (5/18/12)
<b>Rec #1:</b> Continued								Can Pat Harrison write letter or talk to Inova?  We lack mechanisms how to address coordination efforts with private providers, especially with Inova  INOVA and private providers must be at the table, not as advisory, but at the planning, decision and governance stages			
<b>Rec#2:</b> Develop explicit agreements or requirements (non-statutory), in collaboration with private providers, nonprofit or not, for sharing the burden of caring for the uninsured and safety net patients. Information about gaps in health needs not being met will help county and Commonwealth officials assess the wisdom of more formal requirements for private health	Lack of incentives to private providers to provide reduced cost or charity care; What is our plan locally to meet the demand?  With the number of individuals coming into the system with insurance, they will need travel, registration, and various other ancillary, but important, services. How will these be funded?	We lack a business mechanism – what is our business model?  Add Hospice to safety net providers in report (capital caring)	Environment is changing – recognize there is more of a willingness out there to have regional conversations now, the larger concern is HOW we do that? What is that mechanism to have these conversations? What is the right combination?  Need a regional system planning group.  One jurisdiction managing this scope of work in isolation, is	There is a need to develop wrap around services and maximize efficiencies with those services already in place.	This really contains two recommendations, the latter being related to the above goal of assessment  This recommendation is too vague to be sure it is realistic including how will be reinforced and enforced	Feels there should be more incentives for providers – also an education component to it too. Educate the providers and individuals to take the stigma out of individuals who have Medicaid.	Address physical access to healthcare – (i.e. are the exam room tables accessible?)	Get rid of fee for services model; place more emphasis on adequacy and payment  Find reasonable / equitable mechanism to evaluate ALL the community contributions providers are making  Providers must share in the problem AND the solution  Need buy-in from physicians; not the hospitals themselves, but those delivering	Create incentives for providers to participate in Medicaid, Medicare and health exchanges  Let's not confuse exchanges with safety net providers	Better integration of service provisions and needs assessment, especially around care coordination, fall prevention, chronic care.  Reinvigorate the involvement in the Medical Society of Northern Virginia – incentivize and set expectations for charity care.  Explore opportunities to co-locate services  Provide a local incentive fund for	Interested in leveraging resources with provider community.  Sees the need for the 'broker' or 'navigator' role in the Medicaid business.  MCCP has capacity to grow, but needs to find mechanism for outreach to kids.

# ACTION PLAN

GMU Recommendation	ASSB (3/27/12)	COA (5/16/12)	CAC (5/16/12)	CAAB (4/3/12)	CSB (3/28/12)	Commission for Women (7/9/12)	DSB (5/12/12)	HCAB (4/9/12)	NOVA Access to Health Care Consortium (4/26/12)	LTCCC Med & Soc Services Committee (3/20/12)	MCCP (5/18/12)
<p>providers in the future.</p> <p><b>Rec 2: Continued</b></p>			<p>setting themselves up for failure.</p>					<p>the care. The "normal" is gone where physicians volunteered for emergency room rotation; on call services, etc.</p> <p>Lack of incentives</p> <p>Government should subsidize medical education or pay for schooling. You pay on that debt until you die. Especially primary care</p> <p>Lack of active participation from the Medical society.</p>		<p>health care coordination; several programs already at capacity Task force should start looking at regional approaches to meet projected demand.</p>	

GMU Recommendation	ASSB (3/27/12)	COA (5/16/12)	CAC (5/16/12)	CAAB (4/3/12)	CSB (3/28/12)	Commission for Women (7/9/12)	DSB (5/12/12)	HCAB (4/9/12)	NOVA Access to Health Care Consortium (4/26/12)	LTCCC Med & Soc Services Committee (3/20/12)	MCCP (5/18/12)
<p><b>Rec #3:</b> Develop a strategic and operating plan for centralizing county contracts with all health care and service providers (especially medical sub-specialists). Develop an evidence-based model for integrated service delivery across all county agencies and a support system for care coordination and referrals in Fairfax County.</p>			<p>Why aren't we doing this already?</p> <p>Example: Dental Clinic – if we put our \$ together locally it would be good, but if we looked at it from a regional perspective it would be great.</p>		<p>Is this realistic given the various department mandates from the feds and state</p> <p>Where will the line be drawn for the CSB-MH? SUD? ID?</p>			<p>Suggest using the word “integrate” in recommendation instead of “centralizing”</p> <ul style="list-style-type: none"> <li>Centralizing suggests work happens physically in one place</li> </ul> <p>HCAB should be at the table. Planning stages county vs. setting outcomes; we would have an interest in outcomes; from board; Integration – observation, internal reorg process – better oversight.</p>			
<p><b>Rec #4:</b> Pursue “medically underserved population or area” with efforts to establish a “New Access Point” or expansion of existing Community Health Centers in Fairfax, that enhances Medicaid and Medicare reimbursement</p>	<p>What will happen if the FQHC and private providers will not take Medicaid</p>		<p>Discussed Jeanne Schmidt and Loudoun merger. Alexandria opening site in Baileys as new access point.</p>		<p>Is this proposal better done regionally or just Fairfax specifically?</p> <p>This has been under development for long time-if it needs and can be done do it!</p>			<p>There is movement from HRSA with regards on access points; asking for more verification – possible ANSHI next</p>		<p>Develop a more regional approach – continue to build partnerships with other Community Health Centers.</p>	

# ACTION PLAN

GMU Recommendation	ASSB (3/27/12)	COA (5/16/12)	CAC (5/16/12)	CAAB (4/3/12)	CSB (3/28/12)	Commission for Women (7/9/12)	DSB (5/12/12)	HCAB (4/9/12)	NOVA Access to Health Care Consortium (4/26/12)	LTCCC Med & Soc Services Committee (3/20/12)	MCCP (5/18/12)
<p><b>Rec #5:</b> Expand the use of existing streamlined eligibility systems. Support current efforts to expedite utilization of the new cross-program integrated eligibility system the Virginia Department of Health and Human Resources is currently developing to combine eligibility for multiple programs across the secretariat.</p>					<p>Is it the Secretary of Health and Human Resources?</p>		<p>ADA compliance concerns Special attention should be given to persons with disabilities regarding ability to use automated systems and self-navigate</p>				
<p><b>Rec #6:</b> Invest in uniform and integrated information technology that supports a comprehensive and coordinated array of clinical care and administrative functions (including billing) across all county health and human service agencies and programs.</p>					<p>Focus on the use of HIE  Include the mention of EHR</p>		<p>In general, there is a lack of alternative formats in technology to address access barriers – especially for sensory/interpretive impairment.</p>				

GMU Recommendation	ASSB (3/27/12)	COA (5/16/12)	CAC (5/16/12)	CAAB (4/3/12)	CSB (3/28/12)	Commission for Women (7/9/12)	DSB (5/12/12)	HCAB (4/9/12)	NOVA Access to Health Care Consortium (4/26/12)	LTCCC Med & Soc Services Committee (3/20/12)	MCCP (5/18/12)
<b>Rec #7:</b> Continue to include dental care as a part of the safety net services and expand access to local dental service programs for more adults. Work with other safety net and community providers to achieve this expansion.		Are any of NVFS referrals going to Sterling?	Absolutely. Oral health should be managed in a more efficient and effective way.	Gaps in Dental Care – a priority area that needs to be addressed	Fully Support						
<b>Rec #8:</b> Prepare the CHCNs to accept an array of payer sources including self-pay, Medicaid, Medicare and private insurance, especially in preparation for expansion of coverage in both coverage types in 2014.	What will happen if the FQHC and private providers will not take Medicaid	Concern about overhead costs CHCN and FQHC's - what is the cost to the community? Tax burden?	If county continues to be a player in the safety net, the County is going to have to accept every source of revenue. It's time to re-evaluate. Will not be viable long term – it cannot keep expanding without accepting revenue sources.  Waiting list between 5-600; Although space was considered the largest issue in accommodating the wait-list, most felt the space issues could be dealt with if policy & funding issues were resolved.		No Additional Input	Focus was on taking a legislative position around Medicaid expansion, especially around supports and resources for the single working women and those affected by DV	Concern expressed about numbers of people on Medicare who are not getting treatment: -Why can't they go to the CHCN clinics? -Why are expenses so great? -Why are Medicaid recipients receiving better services in Virginia than Medicare recipients?	Additional discussion and analysis is needed to understand the impact of raising fees.  Who determines adequacy? Higher the fees, less likely individual will show up.  Make sure you have other entities at the table; careful planning  Benchmark other jurisdictions  If you are going to start saying see Medicare patients you may take on political fight.	Support for coordinated strategies to recruit providers to participate in health exchange, Medicaid, charity care network  Coordination strategies should be regional in nature – and special emphasis on concentrating on northern Virginia strategies		Doctors would rather provide services for free, than take Medicaid patients.

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<p><b>Rec #8:</b> Continued</p>			<p>Would like to see those who we know are going to be Medicaid eligible** and those who will become eligible with the expansion to keep their medical home within the CHCN.</p> <p>Do not think it is fair to say – you are eligible now, so our work with you is now done. (**for example, based on paperwork they fill out, we know individuals who will become eligible in the next 12-24 months. We still treat them. This client base is relatively small)</p> <p><b>Recommendation:</b> Start with current client base that we know will become eligible. Ensure they keep their medical home and receive proper care.</p> <p>What is the approval process from the BOS to start accepting payer mix?</p>					<p>Many see it as another provider – not view it as safety net provider – not necessary a clinic for low insured.</p> <p>Challenges in physicians who are able to afford to give, but choose not to serve the uninsured. Recommend that we examine government and framework – not just look at reimbursement rates</p> <p>Should we be in the business of “who” we should serve?</p>			

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<p><b>Rec #8:</b> Continued</p>			<p>Many start up challenges, costs, technology etc. to deal with first.</p> <p>Report makes large assumptions about the numbers who will become Medicaid eligible.</p> <p>Aren't we still left with the same problems? - If those patients become eligible for Medicaid, we are still left with either incentivizing those to take Medicaid patients, or there will be a shortage of provider doctors because of increased enrollment.</p> <p>Where is Inova in all of this? If there was no CHCN, they would show up at Inova's emergency room.</p> <p>Inova's been building practices around Medicaid too.</p>								

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			Why does CSB accept Medicaid and the CHCN does not? What is the rationale between having two systems?								
<b>Rec #9:</b> Develop an outreach campaign in 2013 to inform the community of the new coverage options and Medicaid expansion coming in 2014. Expand self-sufficiency services to support future Medicaid expansion.					No Additional Input			<p>Campaign needs to include general education about health insurance, not only to people who have never had insurance before, but to employers and those running the exchanges.</p> <p>Underestimating important of this issue</p> <p>Supplement state and federal efforts. County should not assume all responsibility</p>	<p>Good opportunity to also include a coordinated community health messaging – vaccines, flu shots, etc.</p>	<p>Vice versa – county needs to increase its training and education to health providers on services available to low income persons – and ways to connect to a ‘411’ type of services;</p> <p>Seek better integration of information and access; “not poor enough” group is the hardest to reach.</p>	

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<p><b>Rec #10:</b> Plan for some safety net reduction and/or consolidation, since the scale of the insurance coverage expansion under PPACA could be substantial eventually. But since expansion will not be immediate and Medicaid payment rates are likely to remain low, it is important to anticipate newly eligible beneficiaries (maybe most) having trouble finding private clinicians, especially those patients with behavioral health needs.</p> <p>For these reasons, we recommend keeping the CSB at its current scale until after 2016 and reducing CHCN capacity only after reductions in need can be demonstrated.</p>	<p>Plan and identify our priority services – as state funding decreases and resources begin to dwindle we need to start planning for the future</p> <p>Given uncertainties of the existing providers to absorb newly eligible individuals in the health exchanges, what is the capacity for the FQHCs to serve these individuals?</p> <p>Need a detailed, comprehensive plan for outreach to the private physicians in the community on ways to build service capacity – including advocacy on payment rates</p>	<p>It will still be the tax payers burden – just a shift in where the \$'s are managed. May not be at the local level, but still paying federal &amp; state</p>			<p>What year will the baseline level of CSB services be used-there have been reductions every year for the last four or five years</p>			<p>Concerns with wording. GMU should change wording. Take out date reference.</p> <p>Too large of an assumption – to predict.</p> <p>Use excess capacity to eliminate current wait list.</p>	<p>Assure appropriate care provisions for behavioral health needs</p> <p>Cross disciplinary focus is needed</p>	<p>Manage people's (and tax payers) expectations – what should citizens be aware about as the expansion begins? What is the timeline?</p>	<p>MCCP looking to increase their intake of children with behavioral health needs.</p> <p>Is this equitable? Does the county have a "formula" to continue to help those with no means, especially in Northern Virginia?</p>

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<p><b>Rec #11:</b> Create a new government entity and structure which will enable cross sector, cross agency integration, coordination, and planning in order to reorganize access to services through an authority that will manage and/or leverage resources and coordinate cross-agency/cross-sector services and programs.</p>	<p>Ensure transparency – create an education component to the community on implementation of the new entity</p>		<p>Mixed Reviews:  County needs to have more control, leadership, and a mechanism to bring private providers into the system - and in order to that, you need a mechanism to make that collaboration happen.  This is more than just getting people into a room and having more discussions. This is more about making decisions and having the ability to make things move.  Not another Government Entity! Cause too much overlap Don't we have a group, or council that we can already use?</p>	<p>Ensure the right people are at the table moving forward with recommendations; be sure to include the community in conversations.</p>	<p>Ensure coordinated effort - leverage  Concerns seems like another layer that may come with: 1.Administrative cost 2.Move CSB away from its service priorities 3.Concern of impact to CSB's system 4.HSA &amp; INOVA once influencing presence on the authority 5.Caution of advisory to authority given history with HSA</p>			<p>If we don't know what this authority will do, how can we agree to the recommendation?  This implied an authority would be given the ability to decide up on service (the who and what) outside of the BOS purview?  Will this reduce HCAB to just be responsible for budget? Will all our services be part of this entity?  Changes to HCAB charter?  Why can't we do this with something already existing?  Lack of coordinated planning around safety net services  Lack of agreed upon mechanism to receive information. Still work in silos.  Staffing functions?</p>		<p>There needs to be a public awareness</p>	

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								<p>Ensure there is a mechanism for including private providers in these discussions for buy in.</p> <p>What are the incentive for private providers?</p> <p>Agreed upon resource allocation?</p> <p>Be cautious about planning</p> <p>Community MUST be at the table</p> <p>Inova must have a voice</p>			
<p><b>Rec #12:</b> Develop a privately-funded evaluation program for the proposed Entity, wherein independent contractors conduct a gross and net impact analysis and report to the Board of Supervisors (BOS) every five years (however, the first evaluation should be initiated following the first three years of implementation). Evaluate the program by the priorities</p>					<p>Privately funded? or county funded?</p> <p>Three year question</p>					<p>Would like to see evaluation from a financial impact - to the County, Residents and Programs.</p>	

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determined by the BOS.											
<b>Other Comments</b>	Concern with solving transportation access and coordination for those with health needs.	Concern about integration of Pharmacy/medicine management into well-being of patients		Prevention efforts – Incentivize those in SNAP to eat healthier;  How will the Pharmacy program be handled?			Legislation is needed to cover service provisions under health insurance for those with a disability to ensure equitable coverage.	Concerns with validity of analysis.		Transportation access regionally; explore use of state funds to expand use of Logisticare services for health, wellness and prevention; coordination of FCPS and County buses and routes.	

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