HMA

HEALTH MANAGEMENT ASSOCIATES

Creating an Integrated Approach to the Care of Vulnerable Populations in Fairfax County: A Work Plan

PRESENTED TO
THE FAIRFAX COUNTY HUMAN SERVICES SYSTEM

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Introduction

In January, 2014, Health Management Associates (HMA) was engaged by the Fairfax County Human Services System to develop an implementation strategy that would build upon recommendations made in previous reports and task forces assembled over the past several years and that would result in the development of a seamless and integrated system of health care delivery for vulnerable populations living within the County. To accomplish this charge, HMA assembled a team of seasoned staff with extensive experience in the development of community-based approaches to care delivery, including: clinicians (medical and behavioral health), information technology and finance experts, and policy staff with expertise in organizational models (both for public agencies and for multiple-provider community-based networks).

Over the course of four months, the HMA team: interviewed nearly 100 individuals (from both within the County system and throughout the broader community); reviewed all previous reports; researched issues particular to the Fairfax situation; drew upon experiences from other communities, and; met with Human Services leadership to discuss our proposed approach to assure the potential for implementation within Fairfax County.

The report that follows is meant to be a living document; a set of steps designed to build upon Fairfax County's strengths to assure the implementation of a new approach to health services delivery that both maximizes the efficient use of all resources (internal to the County system and existing in the larger community) and assures a more effective and satisfying experience for those who seek care.

HMA believes that Fairfax County has the historic commitment, the quality programs, and the visionary leadership to take the steps necessary to create and maintain an innovative, collaborative, transparent, cost-effective and high quality health care network for its most medically fragile residents.

It has been our honor to participate in this effort.

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Executive Summary

In December of 2010, a group of County staff and community stakeholders began working together as the Fairfax County Health Care Reform Task Force. They collaborated to develop the tenets of an effective approach—in light of impending health reform--to both assure the most effective delivery of the full array of health services to those residents of the County who most need them and to improve the overall health status of the community. This effort culminated in the issuance of a report by George Mason University (GMU) in 2011 with specific priorities identified that would move Fairfax County closer to these goals of improved delivery and better health outcomes. The GMU plan was endorsed by the County and, in January of 2014, Health Management Associates (HMA) was engaged to take this process to the next step: implementation of the key GMU recommendations, including:

- develop specific agreements among all providers for sharing the burden of caring for the estimated 144,000 uninsured;
- establish an evidence-based model for integrated service delivery across all agencies and programs within the County's Human Services System;
- expand the use of a streamlined eligibility system;
- invest in integrated IT solutions across all County departments and programs;
- include dental as a critical safety net service; and
- create a new organizational structure to enable cross-sector, cross-agency coordination.

In addition to assessing the steps needed to implement these recommendations, HMA sought to incorporate the current Human Services work in building integrated, system-wide approaches to core goal areas of: public/community safety net integration; revenue strategies and policies; information and data sharing; leadership and stewardship; and evaluation and planning. Thus, this HMA report is actually a work plan for realizing the goals and priorities that had already been set and embarked upon through a highly inclusive process.

HMA established its proposed work plan through a process that included individual interviews with over 100 people (including Countystaff and with providers and stakeholders throughout the community), review of all IT initiatives currently underway, exploration of various financing opportunities, thoroughly understanding of the current role of all providers currently serving the Fairfax community, learning State strategies and priorities, extrapolating from lessons learned in similar communities, and, most importantly, discussing the proposed implementation steps with County leaders to assure the success of the work plan.

Why Are We Doing This?

The implementation plan that resulted from this investigative process was built upon the following key goals:

- *The County should be the best possible steward of health dollar*. By assuring that its own services are functioning as a tight system of care, duplications and gaps in its processes and services can be identified and resolved.
- *The County should construct better partnerships with other providers in the community.* In order to meet unmet need, and to maximize the institutional contributions of all providers, a rational, equitable, transparent and seamless network should be established.
- *The County should assure that a more sustainable safety net will be available to those who need it.* A financially sustainable model must be built upon the opportunities available through all participating providers of care.
- *The County should assure a better experience for those residents who need its health care services.* All services (medical, behavioral health, care management, etc.) required to improve health status need to be highly integrated and infrastructure in place to assure effective transitions.

What Needs to be Done?

The following actions should be taken promptly to *address critical functions* necessary to meet the goals identified above:

- Negotiate the elements of a safety net health care network with critical provider partners (addressing both services and support systems) *in order to* assure an equitable and transparent delivery system for those populations defined as having the greatest need for managed access (those covered by Medicaid, the uninsured).
- Agree upon and establish an organizational structure to promote the implementation and maintenance of the integrated delivery system for vulnerable populations across Fairfax County *in order to* provide a vehicle for collective planning, problem-solving, accountability and resource investment.
- Establish an internal and cohesive County structure *in order to* maximize efficiency and effectiveness of its health and human services and to solidify the County's role in the delivery of health care as part of a community-wide network.

- Adopt a plan (and timeline) for unified data and information exchange *in order to* assure that services are developed and delivered based on evidence of effectiveness and knowledge of patient need.
- Give priority attention to streamlined enrollment and eligibility processes and information systems *in order to* assure that those seeking services are screened quickly and linked with the care that they need in a timely manner.
- Ensure financial leveraging and accountability *in order to* achieve maximum sustainability.
- Support County leadership and a clear decision-making process *in order to* both make the difficult transitions needed internally and to lead the establishment of a unified and community-wide approach.
- Organize and strengthen citizen input to guarantee effectiveness and assure a system-wide focus *in order to* preserve the unique role of public participation while assuring the effectiveness of that participation.

What Specific Actions should be taken?

HMA has identified and recommends specific actions that should be taken in order to meet the goals identified above for the 144,000 uninsured, as well as the Medicaid population, that experiences problems with access and coordination of care within Fairfax County. These recommendations are listed below.

Creation of a Fairfax County Community Health Network: HMA Recommendations

1. The County should develop an outline of the proposed Community Health Network, identifying broadly how such an entity would function and what major providers would be sought to participate in this new collaboration.
2. The County's Deputy County Executive for Human Services should convene a small plenary group of critical safety net providers for the purpose of creating the Community Health Network (CHN).
3. The population to be covered, at least initially, should be identified as the uninsured and Medicaid-covered residents of Fairfax County.
4. A plan should be developed for the services needed for the population, the potential providers of those services, and the infrastructure needed.
5. An organizational model should be agreed upon.

6. A short-term as well as a permanently sustainable financing plan should be established to support the CHN.

This initial development process should be completed within six months.

Internal Reorganization of Fairfax County Human Services System

1. Clear reporting, decision-making and accountability should be established within the Fairfax County Human Services System.
2. The organizational reporting structure of all County operated and funded programs, services and contracts related to the direct delivery of health care services should be redesigned. The County should consider creating a new Department, Fairfax County Healthcare Services (FCHS) using a creative structure or phased approach to accomplish the goal of "oversight, planning and responsibility" for all County health care delivery.
3. The County should move enrollment, eligibility and screening functions from all Human Services departments and elevate to a system-wide "front door" function.
4. Individuals should be identified as Finance Director and IT Director for the entire County's Human Services System.
5. Current efforts embodied in the "Countywide Service Integration Planning and Management Unit"—as well as other planning and evaluation programs from throughout the system—should collaborate as one planning unit for the Human Services System.
6. All existing case management services in all Human Services System departments should be identified and eligibility criteria, staffing (numbers, qualifications, case loads, Medicaid reimbursement), and functions, and develop model(s) determined for all populations served.
7. The further consolidation of Departments within the Human Services System should be considered to ensure maximum efficiency.
8. The most effective approaches to assure productive citizen input should be assessed and implemented.
9. The Human Services System should work with other health-related aspects of units reporting to County government (e.g., Sheriff, fire department) to assure maximum utilization and coordination of resources.

The exact organizational structure and reporting lines should be determined by Human Services leadership, with the organization of health services and the "front door functions" as the top

priorities. These organizational structures should assure clear accountability, integration, and acting as one system.

IT Initiatives to Support Integrated Care Delivery

It is important to note that many of the recommendations that follow—and the capital investments that they require—should be the responsibility of the community-wide network, not only the County.

1. Secure a single eligibility and enrollment (E&E) system for County health care programs (and potentially all health and human service programs).
2. Agree upon a single IT administration system for the Community Health Network that focuses on connectivity of the various providers.
3. Invest in—as a community-wide network—software products that could reduce the need for face-to-face specialty care access (i.e., e-consult/e-referral/telehealth).
4. Continue to build a Health Department EHR as the proposed safety-net health care network would benefit greatly from the Health Department being able to exchange population health and clinical data captured electronically.
5. Acquire—either as the County or through the community-wide network—a Care Management tool with the following functions: patient profiling; encounter history; assessment findings/observations; modeling; and care planning and care plan management.
6. Utilize select Health Information Exchange (HIE) services, enabled by client consent and HIPAA compliance, which are required for the proposed care management solution to operate to its maximum effectiveness.
7. Establish EHR interfaces for the providers within the community-wide network.
8. Establish a data analytics unit within the Human Services System.
9. Implement three high-priority "macro/global" initiatives: reach agreement across all County health care programs on Information management, exchange and security standards; develop a more effective, responsible and manageable governance structure for the proposed IT initiatives, which cut across multiple health care programs; complete an in-depth review and gap analysis of existing information systems in accordance with the seven "decision point" questions and the four "IT architecture" questions noted in this HMA report.

10. Sequence IT initiatives based on initiative interdependencies, the projected level of effort associated with each initiative, the cost of the initiatives, and the potential short-term impact associated with some initiatives.

Finance Recommendations to Support Integrated Care Delivery

The HMA recommendations are divided between those which would require the cooperation of the State and those which would not.

Require State Cooperation:

1. Claim federal matching funds for all screening efforts performed for County--funded programs.
2. The County should provide the State share to provide for the high end of Medicaid managed care rates to be used in Fairfax County.
3. Medicaid managed care contracts allow the County to make a match from an Intergovernmental Transfer (IGT) and claim the difference between the Medicaid payment and their full cost of the service including overhead. The County should take advantage of this opportunity.
4. The County should determine if there are opportunities for a "Nursing Home Upper Payment Limit" (UPL) payment by ascertaining how far the Birmingham Green facility payments are from the Medicare limit.
5. The County should apply for a Home and Community Based Services waiver that includes Assisted Living Facilities.
6. Evaluate Adult Day Care services to recoup expenditures through Medicaid eligible activities and functions.
7. Consider working with the state and the managed care plans to pay a per member per month payment for school health services, assuming that there is no Medicaid payment currently for school health services.
8. Work with the State to gain federal approval of pilot programs with more robust services and payment streams in Fairfax County supported with County match.
9. The County should ask the State to request from CMS to allow Medicaid funding for housing bonuses to providers.

Do Not Require State Cooperation:

1. Explore the benefit of transferring specific services currently delivered directly by the County that are stand-alone services, not in a continuum of care, to private providers who may be better able to integrate those services in a more comprehensive way.
2. Establish a County billing office that has high level Medicaid experience.
3. The County should hire or contract with a Medicaid expert who can work with the County and State to maximize available federal programs to benefit clients clinically and the County financially.
4. Implement those recommendations in previous reports that would improve financial performance of Human Services System' agencies.
5. Consolidate all County pharmacy programs into one for efficiencies, with satellites in current locations.
6. Consider attempting to extend the current agreement with Molina to continue to manage the CHCN clinics, as this relationship appears to be very successful; and consider expanding services to the Medicaid population to meet demand and explore securing FQHC-look-alike designation in order to maximize revenue potential.

What Is the Timeline to Needed to Get this Work Done?

It is important that, in implementing the recommendations described throughout this report, a delicate balance is struck between the need to maintain active involvement of key stakeholders and the broader community while, at the same time, moving forward on a clear path, with specific benchmarks met and progress made. It is also critical to remember that the recommended implementation steps detailed in this document are facilitating a general direction that has been widely discussed, debated, and endorsed as the course that Fairfax County will take to achieve a transparent, cost-effective, equitable and high quality approach to assuring the health of all of the County's residents.

HMA believes that it is not only possible to achieve within six months at least the first steps toward both the internal and external reorganizations (and initial IT investments and finance strategies) described in this plan—it is also vital. The longer the effort drags on, the more that both internal and external stakeholders will be convinced that this is yet another report with little hope of implementation. There appears to be widespread interest in making this happen

now, and it will be important to show progress quickly, even though the full reorganization is likely to take longer.

How Will Success Be Measured?

It will be essential to show that there is real value in both the internal reorganization and the implementation of the Community Health Network as a County-wide strategy. Over the next six months, both the Human Services System and the CHN should identify target goals that they will monitor and report in an *Annual Report*—after one year and annually thereafter—to both the Fairfax County Board of Supervisors and the broader community.

Key Findings and Priorities

In developing this work plan, HMA interviewed many stakeholders (see list in Appendices C) in order to assure that any barriers were addressed and opportunities identified. HMA found that there were recurring common themes throughout the interviews, both internally and externally; themes that resonated to HMA as critical in the formulation of an implementation plan rooted in the realities of the current situation in Fairfax County. These themes—heard over and over by multiple sectors—make up the findings that are described below. Further, these findings are candid assessments of issues that must be addressed if the implementation plan is to be successful. **It is important to note at the outset, however, that an overarching HMA conclusion is that Fairfax County staff and stakeholders are extremely talented people, committed to providing excellent programs within the County**. That is an important finding as it is the basis upon which a new approach can be built.

Community-Wide Findings

1. **The Safety Net is extremely fragile**
   The County commitment to providing high quality services to the uninsured is impressive. However, parts of the health care safety net in the broader Fairfax County are fragile and must be addressed in any successful community-wide network strategy. These components are not functioning as a seamless system; there are duplications and gaps that are both expensive to individual providers and organizations and result in a poor patient experience. Primary care access is a significant problem. The FQHCs serving Fairfax County are simply not sustainable at their current payer mix (all are seeing a proportion of uninsured patients that is twice the national average), and their current capacity is extremely limited.

2. **Persistent gaps despite resources**
   Very few of the physicians in Fairfax County see Medicaid patients, and the impact of potential Medicaid expansion—if primary care capacity is not identified—will likely be further reliance on hospital emergency departments. Despite the fact that there are twice the number of specialists in Fairfax than the national average for similar counties, access to those specialties has gone from bad to worse. Because there is little organized access within the County, many primary care providers are sending uninsured and Medicaid patients to UVA or MCV for specialty care. Behavioral health and dental service capacity is a significant concern. Despite strong County commitment to and funding for behavioral health programming and an admirable scope of services provided through the Community Services Board (CSB), mental health services (as well as substance abuse treatment) are not well-integrated with medical care. Hospitals operate in isolation from each other and have had

to work out their own relationships with individual clinics, rather than participate in a larger plan. There is little consistent care management in the community. The enrollment/eligibility system is not as effective a "front door" as is needed. There is little connective and supportive information technology (IT) to leverage as a foundation for data collection, evaluation, monitoring and planning across providers serving the same populations. Most important, there is no clear plan—agreed to by all potential participants--about how to put these elements into a sustainable network of care.

3. **Involvement of the community needs to be focused**
   There are over 35 boards, councils and committees composed of and supported by smart, engaged citizens, County staff and advocates that are focused on specific issues or populations. This citizen participation is an asset but can be an enormous expenditure of staff resources and require intensive coordination responsibility on the part of members of the respective advisory groups. The potential for program specific policies and procedures that are in conflict, overlapping or inconsistent with each other occurs when advisory bodies are not provided with a full picture of system impacts on policy and resource decisions. They are not able to see who is falling through the cracks system-wide. Rather they only see who is directly affected by the programs which they are charged to oversee or review. There must be both an acknowledgement of the importance of community input and a commitment and supporting structure to leverage this significant and precious citizen resource into the most effective force possible, particularly in relation to the health care services offered by the County. Ultimately, a vision must emerge that recognizes the health of the community as a whole and supports consideration of health in all policies.

4. **Culture of addressing problems through committees**
   With the many committees and task forces, there is widespread expressed frustration when there is no action or discernable outcome as a result of the extensive effort and input expended by citizen volunteers, providers, and County staff. There is limited accountability and sense of movement or resolution on issues addressed in many of these committees.

5. **There does not appear to be widespread knowledge about the need for change**
   Although many believe that the way that health care is delivered (particularly for vulnerable populations) needs to be better coordinated, making these changes in the health care system has not been a primary focus for County government. The case needs to be made to all key stakeholders that integration makes fiscal sense and ensures that the current problems of access and gaps in care can be addressed in a way that better prepares the County for the future.

6. **Resource abundance in public and private sector**
   There are significant health care and social service resources in the community, in the County programs, and the private sector. These resources, however, are not effectively coordinated, leveraged, and tapped.

7. **Community experience of County can be fragmented**
   The community experiences the County through individual programs or large meetings and task forces. They are not seen as an integrated system. There is no one "County voice" and the lack of a clear message can be confusing and, sometimes, contradictory.

8. **No community-wide plan for access following Medicaid expansion**
   If Medicaid expansion is enacted in Virginia this year or next, there is no plan in the County to accommodate the additional 27,000 who would gain coverage in the County.[1] While this will be a particular problem for the State and managed care plans, it is also a concern for the County, who has a mission to assure the health of the community.

9. **No equitable community-wide approach to the uninsured population**
   Providers are not coming together to determine 1) the needs of the uninsured population, 2) who is responsible for which component of service, and 3) what outcomes are expected and how these outcomes are monitored.

10. **Absence of a consistently productive relationship with Inova**
    Inova is the largest health care provider in the County. It offers a significant level of charity care in the community, and it is providing individual programs and services to support the safety net – including diagnostic services to the FQHCs and the County's CHCN clinics. However, given its significant resources, the contribution of Inova might be leveraged more strategically in meeting the needs of the uninsured and low-income individuals. If the County, working with Inova and other providers, had a clear plan that met providers' institutional needs and included the expected role of each provider (and the County), it might be able to influence how Inova participates as a partner in improving access to more effective care.

11. **Need for someone to take the lead**
    In order to come up with a single, integrated plan for uninsured and low income residents of the County, and secure the commitment of each party to play a role in that plan, leadership is required. If the County can manage to integrate its own operations and assure maximum effectiveness, define its own responsibilities in an integrated network, guarantee an equitable and accountable division of responsibility among all providers, it would play a needed leadership role.

[1] Estimate from the George Mason University report "Recommendations for the Fairfax County Health Care Reform Implementation Task Force".

Internal County Findings

1. **There is no one unified vision of the County role in health care in the community**
   Multiple opinions exist about the role or roles the County should take in assuring the "health of the public." Is it a provider of certain programs that no one else can provide? Should its focus be on broad issues related to population health (like prevention, environmental regulation)? Should it be a convener of all of the disparate providers of health and social services within the community (and, in that role, what is its responsibility to lead and ensure that actions are taken)? What is the County mission? And what does integration really mean in terms of the County's mission and allocation of resources? These questions must be answered.

2. **Silos between and within Departments can be a significant challenge**
   Because of the County's history and culture, reinforced and sometimes driven by priorities and directives of State and federal mandates, it is unclear what barriers will be put up to achieve maximum effectiveness and efficiency within the County's health and human services programs. Although there appears to be real understanding at the senior levels that change needs to occur and that silos need to be broken down, it is likely there will be push-back when it comes to restructuring and consolidating programs, eliminating ineffective services, and maximizing impact.

3. **Reports and recommendations appear to have been inconsistently implemented**
   The recommendations from the various reports related to the readiness of the County for health reform are very similar and, for the most part, HMA agrees with their conclusions. However, few of the recommendations have been implemented. The community and, to some extent, County staff appear to have a sense that reports will not result in significant change.

4. **Finance and ACA opportunities may not be maximized**
   There may be Medicaid claiming opportunities in a number of areas which the County has not yet aggressively pursued. In addition, federal demonstration programs for people dually eligible for Medicaid and Medicare and health homes might result in additional resources. Pharmacy consolidation might reap savings. Prior reports have pointed to billing issues that need attention. A thorough review of finances should identify these opportunities.

5. **Data are severely lacking**
   Data gaps exist, and it is unclear how much of this deficit is due to system inadequacies and how much is due to how staff is utilizing existing information. Because County leadership has not had good information to guide decision-making or to track effectiveness of its services, there is limited accountability and no data by which to evaluate results and overall progress in meeting agreed upon objectives and outcomes.

6. **Information systems are fragmented**
   Different departments have different systems that do not relate to each other. There appears to be a significant sense of "risk aversion" related to sharing information throughout the County—and the conclusions about sharing of patient information seems to be overly conservative and not consistent with what HMA is seeing in other communities. This fragmentation must be addressed within the County and must be seen as a priority as well for the larger network of providers.

7. **Departments and programs can work against each other if not better coordinated**
   Services provided in one department can be significantly affected by policy decisions made in another (or even by two programs within one Department). There is no clear vehicle for ensuring that an outcome-driven view is taken about cross-program/department initiatives.

Conclusions from Findings about Issues to Be Addressed Quickly

The key findings above represent critical issues that must be addressed head-on in any work plan to assure effective implementation of an integrated delivery system in Fairfax County. The following actions should be taken promptly to *address critical functions*:

1. **Negotiate the elements of a safety net health care network with critical provider partners (addressing both services and support systems) *in order to* assure an equitable and transparent delivery system for those populations defined as having the greatest need for managed access (Medicaid, the uninsured).** A comprehensive integrated delivery plan built around the population of the uninsured and Medicaid covered residents of the County should be constructed by the providers who will deliver services. The plan must ensure equity of contribution among the participants, maximize all available resources and provide for an infrastructure (i.e., care management, enrollment, referral systems, connective IT). Once a tentative plan is developed by the providers, it should be rolled out for public comment and then implemented.

2. **Agree upon and establish an organizational structure to promote the implementation and maintenance of the integrated delivery system for vulnerable populations across Fairfax County *in order to* provide a vehicle for collective planning, problem-solving and resource investment.** The organization of the community-wide network must ensure that all key providers are involved in decision-making and are held accountable for their participation in the network.

3. **Establish an internal and cohesive County structure *in order to* maximize efficiency and effectiveness of its health and human services and to solidify the County's role in**

the delivery of health care as part of a community-wide network. Clearly lay out a timeline for priority areas for implementation, potential financial gains to redirect to fill gaps and leadership structure that will ensure that the County health and human services function in an effective system as the hub of a coordinated and integrated Safety Net.

4. **Adopt a plan (and timeline) for unified data and information exchange *in order to* assure that services are developed and delivered based on evidence of effectiveness and knowledge of patient need.** Resolve current obstacles related to what may be misperceptions about the barriers to a comprehensive data system for patient information and also ensure that data (from both County programs and contractors) provides the information needed to make decisions about policy and program resource allocation.

5. **Give priority attention to streamlined enrollment and eligibility processes and information systems *in order to* assure that those seeking services are screened quickly and linked with the care that they need in a timely manner.** Current processes are obstructing timely access and must be addressed as a system-wide priority. Ideally, the County should provide a single mechanism for "no wrong door" eligibility determination and enrollment for all health care programs.

6. **Ensure financial leveraging and accountability *in order to* assure maximum sustainability**. Priority should be given to 1) pursue all available sources of revenue maximization to support the ability of both the County and the community to provide an integrated delivery system and support its infrastructure; and 2) require a financial assessment of the current allocation of County resources and give attention to opportunities that both enhance programmatic effectiveness and save money.

7. **Support County leadership and a clear decision-making process *in order to* both make the difficult transitions needed internally and to lead the establishment of a unified and community-wide approach.** The authority of leadership for the health and human services system within the County must be clearly defined and supported by the governing body. While collaboration is important, ultimately the leadership must make decisions and have the ability to implement those decisions.

8. **Redesign citizen input to guarantee effectiveness system-wide focus *in order to* preserve the unique role of public participation while assuring the effectiveness of that participation.** It is critical to develop an approach to citizen and community input that maximizes its impact without diluting it by focusing only on discrete programs and services—or sapping the energy of staff and participants alike by an approach that is more focused on process than on results.

Organizational Structure for Community-Wide and Fairfax County Health Care Delivery

In order to maximize the potential for effective and efficient integration of health care services within Fairfax County targeting its most vulnerable residents and communities, Health Management Associates (HMA) is recommending **the simultaneous organization and adoption of two levels of organization and governance structures**. The first action would result in the creation of a community-wide health care network, external to the County but including its health care delivery services as a major network component and its Human Services System leader as a prominent leader, which would integrate the County's health care and support services with community providers (hospitals, health systems, FQHCs, physicians, dental care, etc.) to create a seamless system of care for the designated populations to be served. The second action would be internal to Fairfax County and would consolidate all health care services (whether directly delivered or contracted for by the County) under a new entity reporting to the Deputy County Executive for Health and Human Services.

Examples of both internal reorganizations and community-wide network development are included in the Appendix B. Both efforts should be initiated in Fairfax County—and should occur concurrently--as soon as possible.

Multiple Provider Network for Broader Community

It is clear that there are the resources within Fairfax County to provide a well-organized and seamless system of care for vulnerable populations and communities, building upon the services already offered and supported by the County. There are exemplary programs in both the public and private sectors that include innovative approaches to populations that are often over-looked in other communities. Having significant resources, however, has also served as an impediment for integration and coordination between these providers and programs; Fairfax County lacks a vehicle to bring all to the table in a mutually beneficial and accountable organizational structure. Many programs and services function in isolation from each other. There is, based on HMA interviews of providers throughout Fairfax County, a nearly universal desire to establish a structure in which services are built around the needs of the uninsured and Medicaid populations, a clear and equitable definition and expectation is created of which services are the purview of which provider, supportive infrastructure is put into place to ensure that services are utilized appropriately and that resources are maximized, and that the providers themselves organize this joint effort to assure transparency and accountability. HMA

recommends that this organization be formed to address the needs of the uninsured and any other populations that are determined to experience access problems.

In order to arrive at the recommendations below, HMA reviewed other models of external organizations established to foster multiple provider partnerships. One researcher, Larry Prybil, PhD., of the College of Public Health at the University of Kentucky, surveyed 160 collaboratives between county public health and community-based hospital systems. A few lessons from his research include:

- Conduct a needs assessment in order to build a collaboration around the real needs of the population.
- From the inception, leaders from the public sector and the regional hospitals must come together to establish common goals. A small group representing the leadership of the relevant hospitals and the county leadership, including the Board of Supervisors, should meet to establish goals and priorities. Identify specific benefits to the hospitals involved. Also identify benefits to the full community, not just to the population served.
- Establish a steering committee that includes the county and hospital leadership and the business community.

Descriptions of these reorganizations are attached in Appendix B.

HMA has had extensive experience in establishing community-wide integrated delivery models, particularly focused on safety net populations. It assisted in the establishment of: 1) a multiple provider Coordinated Care Organization (CCO) for the Medicaid population in the greater Portland, Oregon, that included all of the community's hospital systems, three County health departments, FQHCs and private physician groups; a 2) "managed system of care" for 350,000 uninsured residents of Orange County, California that included all hospital systems, the County health department, FQHCs and private physicians—as well as the largest Medicaid Managed Care Organization (MCO) in the County; 3) a network called the "Medical Home Network" serving the south and west sides of Chicago that includes a large academic medical center, four community hospitals, the public health and hospital system and eleven FQHCs that has a contract with the State to manage 170,000 Medicaid lives; 4) a collaboration between public and private providers in south central Los Angeles to coordinate care of Medicaid and uninsured residents of a community with one of the nation's worst health status; and 5) an arrangement between the public health and hospital system serving Baton Rouge, Louisiana with the State's largest private hospital system that resulted in the closing of the public hospital and the redirection of resources into expanded ambulatory care capacity, consolidating inpatient care at the private hospital.

In addition to the lessons learned described above, HMA has learned from these experiences that it is also important to ensure that the following elements are in place:

- *Data are available for making the case for the establishment of a new organization, as well as maintaining support for it.* (There has been work done already to make the case for collaboration in Fairfax County. The George Mason University report provides data on the County Departments involved in the potential reorganization and the County has performed a community needs assessment called the Community Health Status Assessment showing higher incidence of disease, gaps in care and access limitations. The first finding of the Inova community health needs assessment is "Insufficient Collaboration and Coordination Among Organizations Providing Health and Social Services" calling for enhanced collaboration among community-wide healthcare providers, facilities and agencies providing health and social services.)
- *Additional sources of funding are used to support the new entity*, including Medicaid (encompassing managed care, waivers and Disproportionate Share Hospital (DSH) payments), foundations, community benefit funds and the business community. (Some communities used uncompensated care and DSH funds and provider taxes to expand uninsured care. Some engaged the private delivery system by citing the community benefit requirement – using a health outcomes metric, not uncompensated care/bad debt).
- *An organizational structure is established and a service delivery plan established that includes all critical providers* (not just hospitals) including, but not limited to: primary care providers, behavioral health services, specialties, and dentists. This organizational structure should develop and implement a plan that includes all elements of the community's safety net and sets clear expectations for the role of each based on expertise, institutional imperatives and financial maximization.
- *Supportive infrastructure is created and maintained that ensures that there the network functions as a seamless system of care***.** This infrastructure, supported by organizational members as well as the broader community, should include, but not be limited to: enrollment and eligibility systems, connective IT to maximize coordination of patient care, care management, common approach to pharmacy, effective specialty referral systems that ensure appropriateness of the referral and connection back to the primary care provider, and sustained access through a monitored call center available 24/7.
- *A financial model is established to ensure sustainability.* It is likely that there will be front end costs in the establishment of this organization that should be borne equitably by participants and outside (foundation, business) sources. The long term sustainability,

however, will require constant reassessment of the opportunities available (i.e., FQHCs being the central component of primary care for the Medicaid population to draw down cost-based reimbursement, building on services already invested in by hospitals, entering into incentive models to ensure effective management of high-cost patients across the continuum of care).

In addition to the lessons learned through on-the ground experience, HMA prepared a paper on governance lessons that helps inform the choices for the creation of a multiple provider organization[2]. These lessons will be important if the network moves into a more formal structure and include:

- Use data to make the case.
- Ensure accountability. Metrics must be used to measure performance for quality, outcomes and cost, holding providers accountable for each. The performance of the new system must be accountable to the population and community served. Creating a more accountable system is a powerful reason to reorganize.
- Consider a range of organizational models from contractual arrangements to accountable care organizations. Models that address federal and state fraud and abuse laws are preferable and permit sharing of savings, referral of patients, etc. ACOs participating in the Medicare Shared Savings Program (MSSP) are protected from many federal fraud and abuse statutes, but not state ones, unless the state has enacted ACO legislation addressing these issues.
- Choose a legal structure. Corporation, for-profit, not-for-profit, foundation or some other form could be considered.
- Consider Board composition. The federal MSSP requires representation of at least 75% providers on an ACO's board. MSSP also requires that a Medicare consumer sit on an ACO's board. The former ensures that providers are engaged in the future of the organization more fully. The latter ensures consumer representation in the policies of the board. By contrast, creating a Health Authority under Virginia law requires that the board governing a new public/private health authority consists of a majority of consumers.

[2] Catherine Rudd, J.D., *Governance of Accountable Care,* HMA Accountable Care Institute, September 2012.

Creation of a Fairfax County Community Health Network: HMA Recommendations

HMA recommends the following actions:

1. **The County should develop an outline of the proposed Community Health Network, identifying broadly how such an entity would function and what major providers would be sought to participate.** It will be important, from the beginning, to show some support from Inova in this collaborative effort as that system has the broadest scope of services to be integrated into the network.
2. **The County's Deputy County Executive for Human Services should convene a small plenary group of critical safety net providers for the purpose of creating the Community Health Network (CHN).** This plenary group should consist of the leaders of the dominant providers of care to the medically vulnerable in the County: Fairfax County (representing CHCN, CSB and the contracts for care it supports); Inova Health System (representing its hospitals, behavioral and long term care services, physician group and insurance products); the FQHCs serving Fairfax County residents; Reston HCA Hospital; and Kaiser. There should also be a representative of the dental community as well as a selected individual to assure broader community (including business interests) input into this initial process. There may be other critical participants; however, pains should be taken to keep this group small in order to produce an initial organizational model which the larger stakeholder community will be asked to review and endorse.
3. **The population to be covered, at least initially, should be identified.** In order to move this integrated delivery approach as quickly as possible, the initial focus of the CHN should be the uninsured, Medicaid and CSB populations of Fairfax County. However, a case could be made that access for some sectors may be added to this target population earlier rather than later—including those newly included in the health care exchange that may be having access problems. An immediate task will be to define the CHN population (quantified, located and current health status and healthcare utilization described)—work that has been largely addressed in several reports and therefore would not necessitate a significant delay in the establishment of a scope of service and organizational model.
4. **A plan should be developed for the services needed for the population, the potential providers of those services, and the infrastructure needed.** Once the population is identified, an estimation should be made of the elements of the service delivery model: primary care capacity, expectations of specialty and diagnostic demand, infrastructure support (IT, Care management), etc. An inventory of existing programs and services should be matched to the anticipated demand and "assignments of responsibility" made

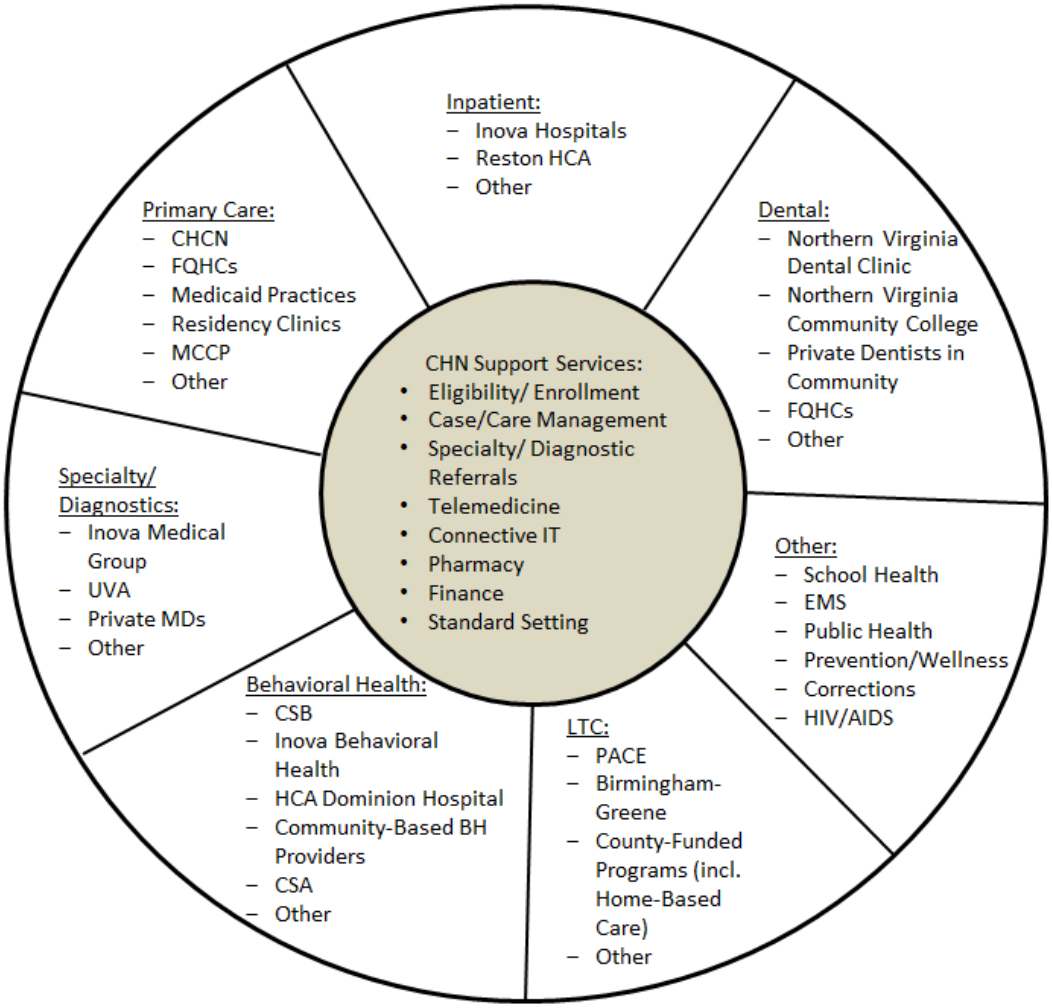
and gaps to be filled identified. From current reports and interviews conducted in the development of this work plan, it is clear that primary care capacity, specialty access, transitions from ED and inpatient care, assurance of primary care access for the serious mentally ill and overall management infrastructure will be some of the first gaps to be addressed. Figure 1 depicts the potential network and the range of services.

5. **An organizational model should be agreed upon.** An organizational structure should be developed that will take the CHN through the initial phases of operation. It is likely that the organization will mature over time (may decide to expand populations covered, could enter into agreements with health plans, etc.) but the initial structure should ensure that the leadership of each participating provider is engaged in the developmental phase. The organizational oversight must be equitably representative of what each provider brings to the table but should also include roles for consumer and community input.[3]
6. **A short and longer term financing plan should be established to support the CHN.** Analysis of all available start-up (particularly for infrastructure needs) and support funding should be made and a financial sustainability plan (including potential collaborations with health plans) adopted, building upon existing spending and opportunities available.

This initial development process (recommendations #1-5) should be completed within six months.

[3]HMA did some research on the authority structure in current statute. It is in Appendix A.

Figure 1. Community Health Network (CHN)



There has been significant interest, particularly among those stakeholders and providers whose interests span an area beyond the confines of Fairfax County—northern Virginia and even beyond—to develop a regional approach to integrated delivery of care for vulnerable populations. The model discussed in this report should be viewed as a first step; and areas of potential replicability and expansion to other counties should be continually assessed throughout implementation. However, it is HMA's experience that it is better to move in an area where there is agreement and build upon the lessons learned.

Delivery System Elements within Fairfax County

To inform the recommendations on internal County restructuring below, HMA reviewed the experiences of other jurisdictions for lessons learned. HMA identified six counties around the country in southern California, New York, and Boston that had undergone reorganizations of their health care services. HMA learned the following:

- Counties recognized that components within departments needed to stop competing for the same resources. They needed to have strategies that maximized the allocation of resources.
- Full county agency reorganization requires broad engagement of staff across agencies and the equal distribution of "losses" in staff and effects of efficiencies. Reorganization resulted in streamlining staff and redirecting savings to services.
- Some counties in California used an office of integration or committee for health care issues to propel the reorganization. However, the ultimate decisions about restructuring must be decided and implemented by leadership.
- In some instances, counties sought legal authority for major changes, and their governing bodies were brought along throughout the process.
- Eligibility and enrollment were streamlined in some Counties to ensure an optimal application process and presumptive eligibility.
- Analysis of overall financial impact was an important element of the reorganization process, and served to provide justification, both for County staff and governing bodies.
- IT was an essential component in the reorganization process.

To further inform the recommendations below, HMA interviewed Dr. Georges Benjamin, Executive Director of the American Public Health Association (APHA). Dr. Benjamin described a population-based health model that health departments are increasingly adopting. Public health departments are reorganizing into three areas: critical services (mental health and substance abuse, HIV, primary care, etc.); wrap-around services, including case management and home visits, and; community-wide delivery integration convener and data aggregator in pursuit of population health.

In addition, HMA has drawn on its own experience in County-based transformations in making its recommendations about internal reorganization of the programs and departments within Fairfax County. For example and most recently, in a major effort to be ready for the changes inherent in the implementation of health reform, HMA assisted the Department of Public Health of the City and County of San Francisco to: 1) restructure all programs, facilities and divisions related to the direct delivery and support of health care services (hospital, primary

and specialty outpatient, managed care office, behavioral health, coordinated care and case management into one "SF Health Network;" 2) consolidate all community-wide public health and prevention services into the Office of Population Health, and; 3) elevate and consolidate Department-wide approaches to information technology, finance and planning. This effort was the predominate focus for the department and took approximately one year.

Finally, and most importantly, the review of past reports and planning processes internal to Fairfax County—as well as approximately 100 different individual interviews (see list of interviewees in Appendix C) conducted by HMA over the first several months of this engagement—have provided the framework for the recommendations below.

Internal Reorganization of Fairfax County Human Services System: HMA Recommendations

HMA recommends the following actions:

1. **Establish clear reporting, decision-making and accountability within the Fairfax County Human Services System.** The most effective public health and human services systems function as seamless amalgamations of programs and services built around the needs of designated populations and communities. To assure that seamlessness, it is critical to establish a mechanism to jointly plan, prioritize, collaborate and tackle difficult problems together. The Deputy County Executive should establish-and leaders should follow--clear processes for addressing issues as a system, not as independent agencies or departments. Further, the infrastructure surrounding the system—from governance to citizen advisory groups—need to embrace this system-wide approach to human services delivery.
2. **Redesign the organizational reporting structure of all County operated and funded programs, services and contracts related to the direct delivery of health care services. Consider creating a new Department, Fairfax County Healthcare Services (FCHS)** using a creative structure or phased approach to accomplish the goal of "oversight, planning and responsibility" for all County health care delivery. It is essential, both to assure the maximum level of effectiveness and efficiency of the health care services that the County delivers and pays for, as well as to improve the patient experience for those that these services are meant for, to have a formal mechanism to integrate these programs, to identify areas of synergy, to prevent duplication, and to better identify problems in the continuum. The elements of this new network would include, at the outset: the CHCN clinics; the CSB; all dental programs; adult health care services (including long-term care and health services designated for the elderly and disabled), and: *any other programs and services directly related to the provision of health care services (See*

Appendix D for a listing of all potential services to be evaluated). One director, accountable to the Deputy County Executive, would be recruited with both the internal credibility to facilitate this transition and with the experience and skill to operate an integrated system of care and represent the County in the development of a community-wide network for vulnerable populations. The CSB would maintain its accountability to the CSB Board and retain its Executive Director but would be operationally integrated into this new network (see Appendix A for a description of the ability to undertake this change for the CSB). The FCHS would also be a critical component of the County-wide Community Health Network.

3. **Coordinate enrollment, eligibility and screening functions from all Human Services departments and elevate to a system-wide "front door function."** These activities are essential to the effective operation of both the County network and will be a critical element of a County-wide effort to assure integrated care to a defined population. It is critical that this function gets the attention that it requires making it one system-wide effort that has the responsibility for providing infrastructure and support across the entire system. The Deputy County Executive should, then, bring in an entity that has restructured this "front door" process in similar counties to oversee changes needed to make the system more effective for both people to be served and providers wanting to serve them.

4. **Identify individuals to be named as Finance Director and IT Director for the entire County's Human Services System.** There are extensive and complex issues related to both finance and IT impacting the entire Human Services System. It is essential that all elements of both IT and finance are coordinated throughout the various programs and departments, that opportunities for maximizing revenue (including working with Medicaid at the State) and efficiency are prioritized, that the County-wide IT and Finance hear one set of priorities from the Human Services System, and that the Deputy County Executive is presented with recommendations based upon real data. While it may not be feasible (or necessary) to pull out all finance and IT people into one unit, it should be clear that they have a direct accountability to these new positions.

5. **Move current efforts embodied in the "Countywide Service Integration Planning and Management unit—as well as other planning and evaluation programs from throughout the system--into one planning unit for the Human Services System.** This unit will have system-wide responsibility for providing a comprehensive approach to the evaluation of County efforts, provide data analytics, etc.

6. **Identify all existing case management services in all Human Services System departments and determine eligibility criteria, staffing (numbers, qualifications, case**

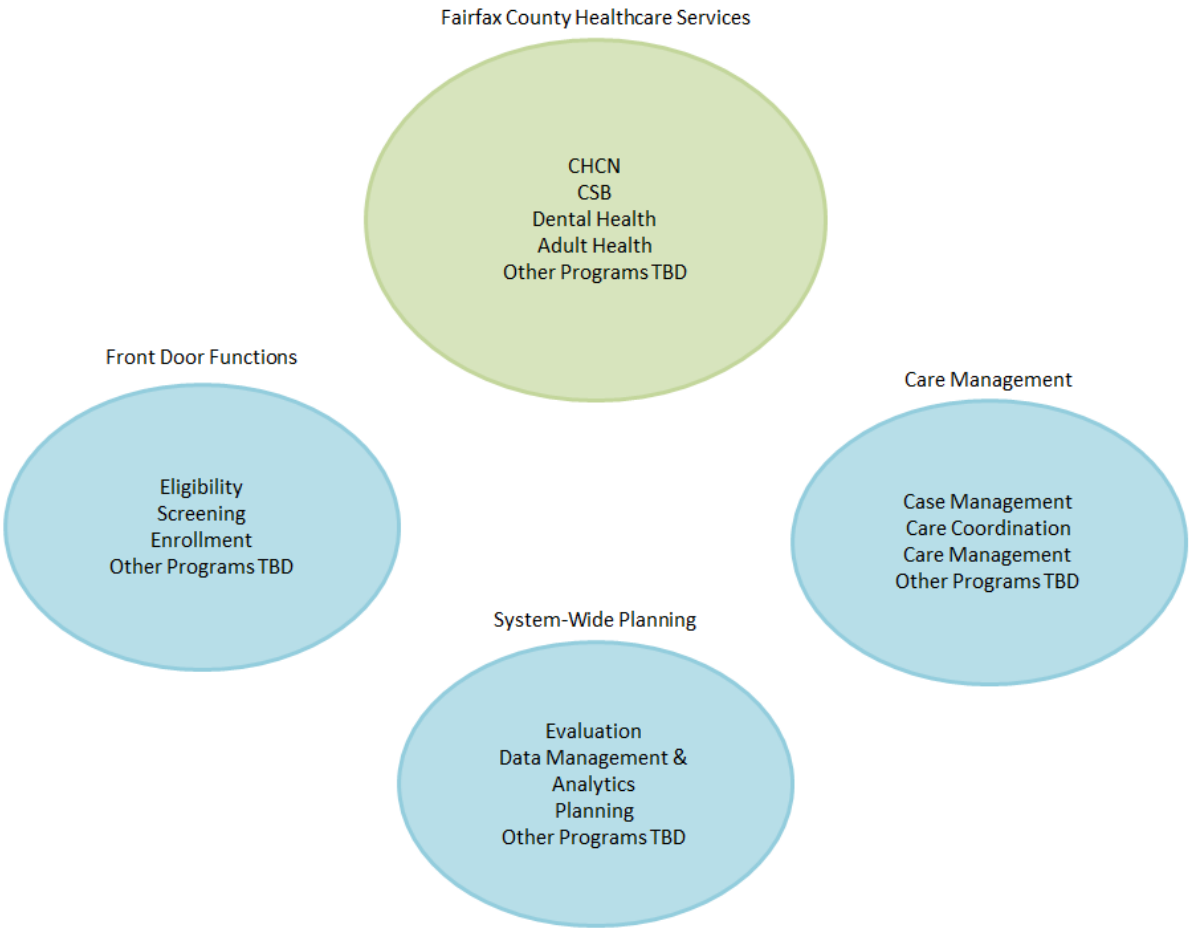
loads, Medicaid reimbursement), and functions and develop model(s) needed for all populations served. Determine role within new care delivery system entity (FCHS) and set goals for how to achieve goal of case management staff working within health care delivery system. This process will also identify the current gaps in care management and case coordination infrastructure that will need to be filled by the community-wide network.

7. **Consider the further consolidation of Departments within the Human Services System to ensure maximum efficiency.** While it is not in the current scope of this engagement, HMA recommends that additional thought be given to the potential for consolidating other County Human Services Departments and programs in order to ensure maximum effectiveness and efficiency.
8. **Assess the most effective approach to assure productive citizen input.** Fairfax County has committed itself to assuring citizen and broad stakeholder involvement in the activities of the Human Services System. This commitment is laudable and must be preserved. The number of these bodies, however, far exceeds the number necessitated by law or regulation and, the very narrow scope of some of these bodies suggests that they could be consolidated. This is a delicate process and must assure that any restructuring actually enhanced the role of the advisory bodies by giving each a broader picture of how their particular area of focus fit into the larger system. A process should commence (involving key advisory body leaders) to review all existing bodies to determine if they could be better utilized, given the proposed reorganization of the Human Services System.
9. **Work with other health-related aspects of units reporting to County government to assure maximum utilization and coordination of resources.** There are additional opportunities for collaboration beyond those within the Human Services System. For example, the EMT functions within the fire department have been utilized in several communities as an extension of the health system (i.e., linkages with primary care appointments for responders to 9-1-1 calls from those seeking medical care, using EMTs as a mental health “crisis response team). Jail health services, particularly under coverage expansion elements of health reform, should be linked into a health care network upon release.

The proposed reorganization of the health care services within the Human Services system is graphically depicted below in Figure 2. The exact organizational structure and reporting lines should be determined by Human Services leadership, with the organization of health services

and the "front door" functions as the top priorities. These organizational structures should assure clear accountability, integration and acting as one system.

Figure 2. Proposed Fairfax County Areas of Integration



Information Technology

HMA recognizes that a critical need within this safety net health care system redesign initiative is establishing the information technology (IT) capabilities that the redesigned system will require in order to operate successfully. To that end, as part of our engagement with the County, HMA proposed completing an **IT capability assessment** and facilitating agreement on the comprehensive **IT solution** that will enable the new safety-net system.

To date:

- HMA has completed the first phase of the IT capability assessment, which was focused primarily on conducting due diligence – interviews and documentation review - understanding how different information systems are used by the different organizations that provide health care services and/or manage health care programs within the County.
- Additionally, HMA has conducted research on how counties and health care enterprises with characteristics similar to Fairfax County have addressed some of the IT challenges that the County faces. Related to this, HMA has also identified experience from prior HMA health system restructuring and accountable care system development projects that we believe is relevant to this particular project.
- Furthermore, HMA has strategized to formulate the **target IT architecture**: a proposed end-state for IT capabilities in the County that will support the new safety-net health care system.

The results of the IT capability assessment and research, in combination with the proposed target IT architecture, are intended to provide both goals and "guard rails" for the County to base decisions regarding:

1. What information systems, if any, should be acquired;
2. What existing information systems, if any, should be phased out or "sun-setted";
3. What existing information systems, if any, should be upgraded, leveraged more effectively and/or directed for use as **the** single IT solution for particular functions;
4. How existing and future information systems should be interfaced to enable as-needed information access and exchange;
5. How telecommunications capabilities would need to be bolstered in support of the new safety-net health system – this would include enablement of mobile computing and telehealth;

6. How information management standards – which includes requirements for capturing or recording certain data such as encounters/visits/contacts as well as agreeing on definitions for certain data elements – need to change so that data needed for the safety-net health care system to perform optimally is systematically captured and made available to providers and managers; and
7. How the evolving IT and telecommunications environment – including what may be multiple IT and telecommunications projects running concurrently – will be governed going forward.

The answers to these seven "decision point" questions become the **IT plan** for the new safety-net health care system. The IT plan will include specific IT initiatives that the County should pursue in support of, and to enable, the new system as well as proposed standards for the management, exchange and securing of information within the redesigned system and a proposed IT governance structure that is more nimble – time will be of the essence for many of these IT initiatives – yet in line with the County's existing planning and program management structures.

IT Capability Assessment

The scope of the IT capability assessment effort included the following activities associated with the operation of any safety-net health care system:

1. Eligibility and enrollment data capture and exchange;
2. Patient demographics and contact information capture and exchange;
3. Health status and risk assessment information capture and exchange;
4. Coverage/benefits information capture and exchange;
5. Capture and exchange of physical and behavioral health history including diagnosis, treatment, drug utilization and provider information (garnered through encounter data from multiple programs as well as provider EMRs/EHRs);
6. Capture and exchange of information on current supports including utilization of human services, housing supports, employment supports, and access to home and community based services;
7. Capture and exchange of care plan information or – ideally - the ability for multiple providers to collaborate in the development and maintenance of a care plan;
8. Facilitation of requests for service authorization, prescription orders (e-prescribing);
9. Capture and exchange of lab results, diagnostic imaging information, prescription fill status and medication adherence;

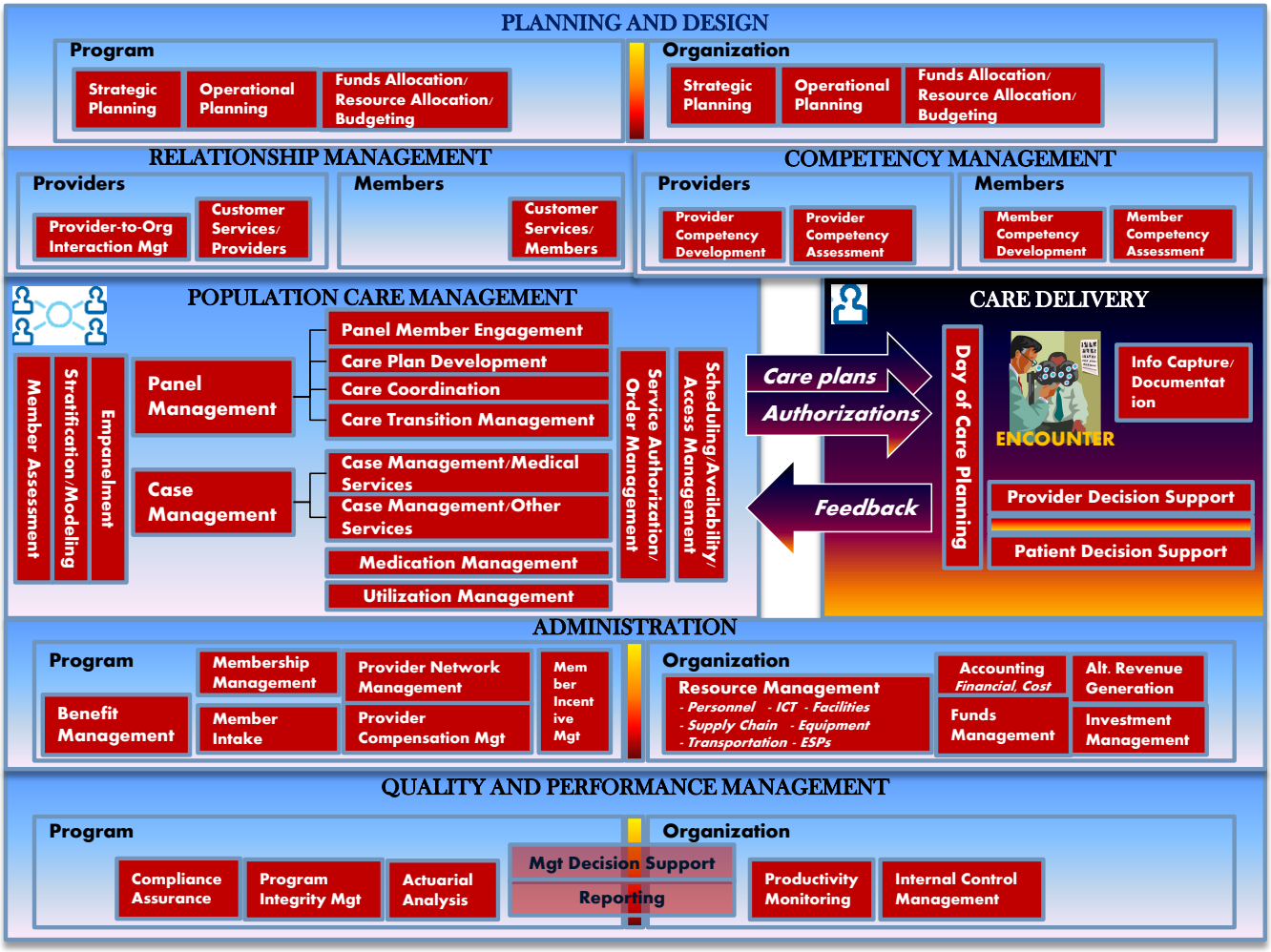
10. Exchange of critical data through the use of query-based exchange, DIRECT secure messaging or other means;
11. Processing of provider compensation transactions (fee-for-service claims, capitation payments, gain-sharing and/or other incentive payments, etc.);
12. Performance management and planning activities related to the safety-net health care system; these activities require reporting of and analytics on data generated out of the above functions; and
13. Data analytics at the provider and county levels as well as generation of metrics for reporting to public health agencies and other entities including, as deemed applicable, the federal government.

The broader framework developed by HMA for conducting these IT capability assessment activities is the **Accountable Care Capability Framework (ACCF)**; the ACCF describes - based on HMA's experience with multiple providers participating in accountable care programs and the government agencies with whom we have worked to design these programs – the business and technological capabilities that health care organizations must possess to operate these programs successfully. The ACCF is comprised of a business function model and standardized definitions for 55 discrete business functions which ultimately roll up under the following business function areas:

- **Administration**: including planning, budgeting, performance management and compliance assurance at the organizational level and for specific programs for which the organization is responsible.
- **Service delivery and management:** including health care services and other essential safety-net health care system services such as case management.
- **Analytics and reporting:** both real-time, in support of service delivery and management functions, and retrospective in support of administration functions.

The ACCF is illustrated in Figure 3.

Figure 3. Accountable Care Capability Framework – business functions illustrated



Due Diligence Interviews and Document Reviews

Following an IT "kickoff" meeting held on March 5th with representatives from DHS, the CSB and other players in the existing safety-net health care system, on March 5th and 6th and again on March 17th and 18th HMA conducted due diligence interviews and document reviews with key stakeholders within the existing health care system; these stakeholders included:

- The Fairfax-Falls Church Community Service Board/CSB
- The Department of Family Services
- Aging and Disability Services
- Adult Health
- Community Health Care Network/CHCN
- Youth Services

- Department of Information Technology
- Contracts Management for Comprehensive Services Act
- Office to Prevent and End Homelessness

HMA also reviewed various documents which provided insight into the current state of IT amongst these stakeholders. The documents we received and reviewed included:

- Human Services IT Plan, last updated November 2013
- Fairfax County Health Care Reform Implementation Task Force November 2012
- Health Care Service Reform Interim Service Integration Workgroup Report Community Transformation Grant, Capacity Building Plan – Year 3
- Information Technology Environment Documentation from CHCN (Molina)

The County and its partners also provided HMA with valuable demonstrations of various applications currently used across human services programs; the purpose of these demonstrations was to gage the potential use of these systems in support of the proposed safety net health care systems. The applications that HMA viewed included:

- eAssist (Coordinated Services);
- Harmony (Aging and Disability Services);
- Credible (CSB); and
- Centricity (CHCN).

The County also provided partial responses to questions posed in a Due Diligence Information Request which HMA prepared and submitted in early February. The HMA team reviewed the responses provided to those questions.

Key Observations and Findings

While it is evident that considerable time and effort has been invested in acquiring and implementing a host of information systems that support the various health care programs administered by the County, it is also the case that these systems are very much fragmented and exchange very little information if at all. That creates numerous complications for the teams actually providing services to individuals within these programs. Moreover, it is certain to create or exacerbate inefficiencies for both clients and providers as information has to be captured repeatedly and the potential for duplicative services or procedures is unnecessarily high. Additionally, the cost of operating and maintaining so many systems will necessarily be

higher than what it could be if these systems were better integrated or – ideally – if single systems were used across programs to perform certain functions. In particular, membership management (which includes eligibility and enrollment) and provider compensation management (which includes processing of claims and other forms of provider payment) are two functions for which costs could be considerably lower in an environment where these functions were performed by single systems. Additionally, there is limited if any validation of the demographic and other information that prospective clients of these programs are providing as part of the eligibility determination process for these programs.

Perhaps more significantly given the primary goal of this project, the current state of health care information systems in the County will prevent it from moving to an integrated model of care and services. Specifically,

- The electronic health record and related encounter charting systems that are currently used by County health care programs do not exchange data.
- There is no automated notification of specific events, such as emergency room visits or hospitalizations, occurring among County health care program providers.
- There is no systematic way for providers of County health care services to access information about the services their clients may be receiving from other programs.
- Information technology is not being used much if at all to augment the capabilities of health care program providers with regards to client diagnostics and treatment decisions, or for these providers to consult with specialty providers outside of their organizations.
- There are limited analytics and reporting capabilities being utilized by health care program providers and the officials overseeing the operations of these programs to:
    - In *real time*, make informed decisions about client services, or
    - *Retrospectively*, ascertain the effectiveness of these programs and, using a "rapid cycle" methodology, adjust and make continuous improvements to the programs.

It is also HMA's conclusion that oversight of the information technology used in support of these health care programs is too diffuse, which might exacerbate and perpetuate the systems fragmentation and might result in investments in duplicative or unnecessary IT. Moreover, while Human Services did publish an IT plan, HMA was not able to discern a clear vision for how IT will evolve within the County in order to move its health care programs to the desired integrated model of care and services. Finally, it is HMA's impression that the existing IT planning and project execution process does not prevent implementation of information

systems which are either unnecessary or possess duplicative functionality. This has resulted in a collection of information systems being used by the County's health care programs which do not enable a "patient centered" model of care and services.

Target IT Architecture – Key Features and Illustration

A target IT architecture is a depiction and narrative description of the optimal mix of IT products and services that should be deployed and properly interfaced in support of the proposed service model; this will include existing IT products and services in addition to IT products and services that may need to be acquired. In the case of the proposed safety-net health care system, the target IT architecture is meant to illustrate how IT can enable more efficient and effective program administration, service delivery and management, and analytics and reporting activities and answer the following critical **IT architecture questions**:

1. How can we improve the use of IT by our behavioral health providers and our contracted primary care service providers with the express goals of:
   - ✓ Saving money;
   - ✓ Saving time;
   - ✓ Reducing or eliminating duplicate effort for data entry, tracking and information systems expense for all functions - from enrollment, eligibility determination, income verification, updating eligibility, tracking utilization, billing/reimbursement from client copay and third parties, all the way to electronic medical record sharing;
   - ✓ Improving outcomes and the client's experience with the health care system; and
   - ✓ Improving the County's ability to perform population health management and community health planning.
2. What possibilities exist for improved data access and exchange – in a secure, and only on an as-needed basis - across health care program providers?
3. What are short-term IT efforts worth pursuing - ideally efforts which are not "throwaway" investments but rather part of something bigger and more ambitious?
4. What IT initiatives should be bypassed because they get in the way of true transformational and interactive systems integration?

The "HIE-powered" suite of information systems that will be needed to operationalize the proposed safety-net health care system will require the following **critical enablers**:

- **Multi-channel intake** integrated to initial screening, health/functional assessment, risk analysis and stratification and treatment/care plan development.
- **Proactive alerts** to providers for – at a minimum - emergency room utilization, inpatient hospitalization, visits to certain provider types and when a member does not obtain a medication refill when expected.
- The ability to access the same authoritative information about a member, i.e. access to a **unified view of member-level demographic, health and social data**.
- The ability to **feed a client's clinical, social and demographic data as well as its service utilization history into a common care management platform**. Agencies and providers already capture some of these data; however the disparate systems and formats in which these data are being captured severely limit their availability and potential value. This is perhaps the greatest challenge to overcome with regards to this capability.
- **Treatment/care plan development enhanced by best practices and real-time intelligence about a patient's status**, e.g. potential drug-to-drug interactions, multiple allergies, evidence gathered from patients with similar conditions.
- **Treatment/care plan administration in a collaborative environment enhanced by patient monitoring** with continuous real-time feeds from multiple systems, connectivity to e-consult and telehealth applications, services such as LifeAlert, personal health records and mobile applications through which patients can enter data and communicate with caregivers. This presupposes that caregivers, service providers and care managers will be able to collaborate effectively, including in "real-time" as needed.
- **The ability to connect with the members themselves via electronic means**, even in real-time if need be. Engaging members in their care is a fundamental tenet of the health homes program. To that end personal health records (PHRs) and mobile or web-based applications that enable monitoring of member compliance with care plan elements such as medication adherence are very important components.
- **Data analytics and decision support capabilities that enable both near real-time and retrospective health status, intervention and outcomes analysis** of both individuals and groups – this includes the ability to compile, aggregate, synthesize, analyze and interpret client data in conjunction with program data for measures reporting, retrospective analytics and continuous program improvement purposes. This capability is usually found in so-called "business intelligence/decision support/data analytics" applications that work off large, multi-dimensional databases or warehouses.

- **Greater provider and care manager mobility** with the ability to – in real time - access needed information and interact with beneficiaries and other health care system resources.

These features of the target IT architecture are illustrated in Figure 4 (next page).

Specific Recommendations

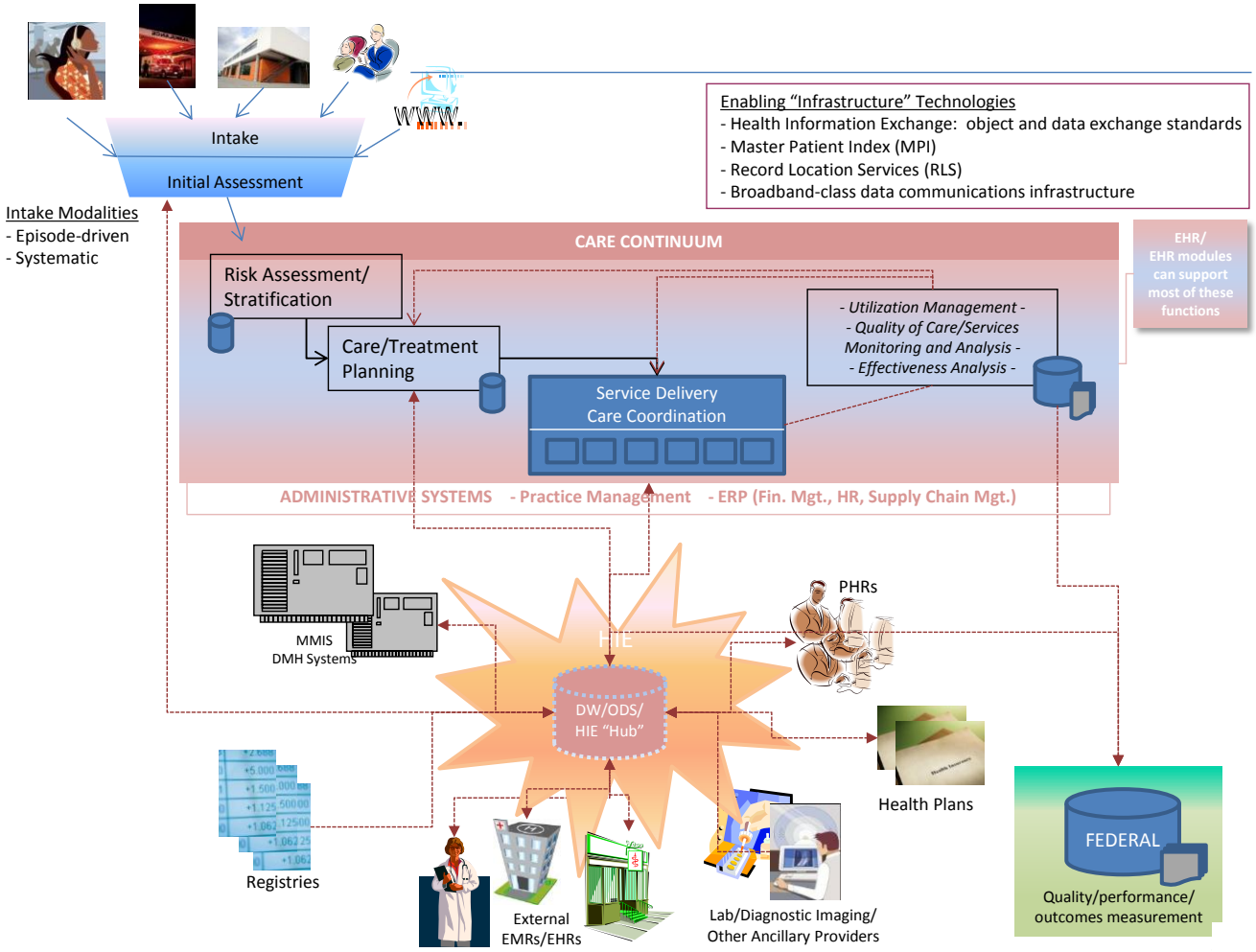
Based on the target IT architecture and on the related IT architecture questions, HMA is proposing specific IT initiatives meant to help the County move in the direction of the target IT architecture while realizing meaningful functionality and performance gains along the way; moreover these initiatives will accelerate and enable the transition to the new safety-net health care system.

It is important to note that many of these recommendations—and the capital investments that they require—should be the responsibility of the community-wide network, not only the County. Following is a description of these recommendations.

IT Recommendations: Program Administration

1. **Single eligibility and enrollment (E&E) system for County health care programs (and potentially all health and human service programs).** Irrespective of the particular health care program for which a client might qualify, County should move to a single system for determining eligibility and managing the enrollment of clients to these programs if its goal is to establish a singular, truly integrated safety-net health care system that seamlessly provides services funded by multiple programs. A single E&E system would make it easier for the County to administer changes in client eligibility for different programs, and would facilitation dissemination of these changes within the County and Community Health Network providers. A single E&E system would make it easier to validate client data against authoritative external data sources (e.g. Social Security Administration, Department of Homeland Security) and to establish interfaces to state systems including VaCMS, Virginia's integrated eligibility and case management system for its health and human service programs including Medicaid.

Figure 4. Fairfax County Target IT Architecture, Community Health Network and In-Scope Programs



2. **Single 'health plan' administration system.** To the extent that the Community Health Network as proposed may operate like a health plan, HMA believes it is essential for CHN to have an integrated system to manage its 'health plan' functions. These functions include but are not limited to:

    a. Benefit management:

    b. Provider management

    c. Claim/encounter processing/recording

    d. Provider compensation management

    e. Program integrity and compliance management

Because these functions are inherently interdependent – for instance, provider compensation for a specific service is dependent in part on (a) whether the service was

a 'covered benefit' for the client who received it, (b) whether the provider who rendered the service was actually authorized to provide it under the terms of his 'contract', and (c) the payment terms associated with that service.

IT Recommendations: Service Delivery and Management

1. **E-consult/e-referral/telehealth**: This functionality encompasses inter-provider collaboration and capability augmentation, particularly of scarce high-demand specialists. Our proposal is to introduce relatively inexpensive e-consult solution - technology that has been adopted by county-based health care systems as well as larger health plans across the country – in conjunction with greater leveraging of existing telehealth resources. A good example of e-consult functionality is a solution from California-based Safety Net Connect; this solution provides for:
    - A web-based secure messaging platform that facilitates the communication between primary care and specialty care physicians;
    - The ability for PCPs to consult with specialists about treatment plans or discuss a difficult case that may or may not need a specialty referral. This collaborative process reduces inappropriate and unnecessary referrals before a visit is even scheduled. The platform can also increase valid referrals by providing specialty guidelines and communicating each Specialist's expectations to the PCP.
    - Efficient storage and management of all e-consults including information generated during the consult.
2. **Health Department EHR:** This initiative is in progress, and HMA believes that it is essential for the Health Department to acquire EHR capabilities. The proposed safety-net health care system would benefit greatly from the Health Department being able to exchange clinical data captured electronically.
3. **Care Management:** HMA proposes that the County acquire a comprehensive solution which we refer to as "Care Management Plus" because it encompasses functionality which is usually associated with multiple functions that fall within the "care continuum". There is much confusion in the health care IT industry when it comes to terminology such as "care management", "case management", and "care coordination". What HMA is referring to here is a truly *integrated* solution that provides the following functionality, all of which is interrelated and designed to empower care managers and

care givers within the redesigned safety net system with the information and tools they will need to build and manage care plans for the system's clients:

a. Profiles – the ability to have a complete, singular view of an individual's health, social, environmental and demographic information based on authoritative (validated) data.

b. Encounter history – also known as a longitudinal person record. In effect this will also serve as a light "community health record" that would sit outside of any single provider entity's electronic health record and deliver "just enough" detail about the last several years of a client's encounters within the safety net health care system and, ideally, other relevant providers (e.g. private hospitals). The initial build and ongoing population of this encounter history will take significant coordination including data exchange agreements amongst the major providers in the safety net system, resolving issues of client consent and clarifying that HIPAA and other federal laws and regulations actually encourage the exchange of health data as long as client consent is obtained and the necessary protections are in place to ensure confidentiality and privacy.

c. Assessment findings/observations – a single application for any safety-net health care provider to conduct and capture assessment information for all in-scope health care programs. This also provides for a single repository for this information which – when married to profile and encounter history information – can provide a wealth of information to providers and critical inputs to predictive modeling functionality.

d. Modeling – the objective of this functionality is to augment the capabilities of providers within the safety-net system by streamlining, and in some instances automating, the evaluation and ultimate "scoring" of a client's health risk and projected health care costs. This evaluation and scoring lays the foundation for informed, evidence-based care planning.

e. Care planning and care plan management – this functionality supports collaborative development of individualized care plans, where all relevant providers exchange treatment and service ideas and are subsequently able to, based on the roles in the care team, access and update care plans. This functionality would also support selective "push" of care plans to clients, client representatives and/or family members, and providers outside the safety net health care system.

There are several IT solution vendors that offer these "care management plus" capabilities.

4. **Select HIE services:** Health Information Exchange (HIE), enabled by client consent and HIPAA compliance, is required for the proposed care management solution to operate to its maximum effectiveness. At a minimum the following HIE services should be implemented; these are listed in what HMA believes is the order in which they should be implemented given the ease and cost associated with each:

    f. Event notification: this would include hospital Admit/Discharge/Transfer (ADT) notifications as well as ER visit notifications.

    g. Diagnostic test results: the focus here would be on electronic lab results (ELR) and radiologist reads of diagnostic images.

    h. Medications/prescriptions: "closing the loop" to ensure that prescribed medications are filled, which also facilitates medication reconciliation. It is our understanding that e-prescribing is already utilized heavily within the county, which is a step in the direction to enabling this specific functionality.

    i. Query based exchange with select external providers: going forward, it will be of great benefit to providers within the safety-net health care system to be able to obtain information about their clients that transcends what they can access within the system. For instance, it would be ideal if the encounter history of a client who may have moved from a neighboring county in Virginia or from a neighboring state (if not a detailed encounter history, a Continuity of Care Record/Document for that individual) could be obtained when that client first touches the Fairfax safety-net system.

These services listed above are not only critical to the success of the proposed safety net health care system, but they will also enable providers within the system to meet Stage 1 and Stage 2 Meaningful Use (MU) criteria. Many of these criteria – the ability to systematically capture patient demographics, orders and prescriptions; provision of health record data to patients; targeted patient lists; systematic identification of patient educational needs; and transmission of summary of care information; to highlight some important criteria – are in line with the *minimal* information management functionality which the proposed safety-net health care system will need. Moreover, meeting MU criteria will determine whether certain federal funds can be accessed to help fund some of the proposed IT initiatives - to the extent that the aforementioned HIE services would also support Medicaid beneficiaries and providers in the county, federal funding may be available to support development and implementation of those services.

5. **EHR interfaces**: Different providers within the safety-net system are using different solutions for encounter charting/recording and managing the patient workflow within their practices/facilities – for instance, the CSB is utilizing a solution from Credible which has been designed specifically for behavioral health services. Given the specific characteristics of providers within the safety-net system, it would be unrealistic for them to migrate to a single EHR and thus they should not be compelled to do so. That notwithstanding, these providers will benefit greatly from the ability to exchange information across their EHRs.

IT Recommendations: Analytics and Reporting

The most recent County Human Services IT plan describes a "data warehouse" project tied to the *Partnership for Healthier Fairfax* initiative. While it notes that there may be Community Transformation Grant funding available to support this project, the status of the project is not clear. Moreover, providers within the safety-net health care system and the program managers responsible for overseeing its operation will need both real-time and retrospective analytics and reporting capabilities that go beyond the data warehouse project's stated objective of implementing cross-agency data collection and reporting on health statistics for residents of Fairfax County. Thus, investing in a robust business intelligence and data analytics platform that supports both provider and program manager end-users will be important. That noted, HMA recommends staggering the timing of the procurement and implementation of this platform until other system initiatives are underway and issues related to documentation of encounters are resolved. That will ensure that the platform will be effectively populated with valuable, complete administrative and clinical data upon go-live. In the interim, HMA recommends that the County engage in a concerted effort to leverage existing systems and the programming capabilities of the Department of Information Technology to implement short-term reporting solutions that would improve the County's ability to manage its health care programs. This could include agreeing to leverage the analytics and reporting capabilities that Molina has already built for CHCN; HMA's assessment of these capabilities is that they are quite sophisticated.

IT Recommendations: Macro/Global

As noted previously, in addition to initiatives that are specifically about acquiring or developing IT solutions there are other imperatives related to the management of IT and information that

the County needs to address promptly in order to implement the proposed safety-net health care system. The three high-priority "macro/global" initiatives that fall within this category are the following:

1. **Information management, exchange and security standards**. This initiative includes reaching agreement across all county health care programs on standardized definitions for certain constructs and associated data elements which cut across these programs. This effort is foundational: the lack of 'harmonization' of data across information systems is often the cause for system interfacing problems and costly system changes. Moreover, it is also essential for health care program providers to document encounters consistently and in accordance with a common format. Within this effort, establishing and enforcing standards for more thorough documentation of services and encounters is absolutely critical. Without these standards, there will be no point in investing in high-powered analytics and reporting capabilities. Finally, it is imperative that a substantial effort be made to build the health care program IT "data dictionary" to prevent confusion when project team members from different agencies or sections come together for meetings and work sessions; this will also be critical for IT vendors and developers.
2. **IT initiative governance specific to health care programs**. Developing a more effective, responsible and manageable governance structure for the proposed IT initiatives, which cut across multiple health care programs, will be critical to the County's ability to implement them in a timely manner. The revised governance structure will need to acknowledge the roles of DHS, the Department of Information Technology (DIT) and the Department of Management of Budget (DMB) in the planning and management of IT assets. For instance, DIT sets certain standards that all county agencies have to conform to, and it provides oversight and has some budget authority over agency IT funding requests. DIT is also a provider of IT services. That notwithstanding, the County must recognize that the implementation of an integrated safety-net health care system is a County priority that has the potential to generate considerable savings to the County; thus a governance structure that is responsive and not overly bureaucratic will be of utmost importance. Moreover, the governance structure must be able to promote agreement on and adherence to an integrated IT platform for the programs within the scope of this project.
3. **Comprehensive health care program IT initiative implementation plan and budget**. We propose completing an in-depth review and gap analysis of existing information systems in accordance with the seven "decision point" questions and the four "IT architecture" questions noted previously in this report. Upon completing this review, the County will

be positioned to update the Human Services IT plan by spelling out which of the proposed IT initiatives will require investments in new information systems vs. enhancements or upgrades to existing systems, whether procurement activity will be required and for which initiatives, and their expected cost of each initiative over the applicable planning horizon. This plan will serve as an input to the County's standard budgeting process.

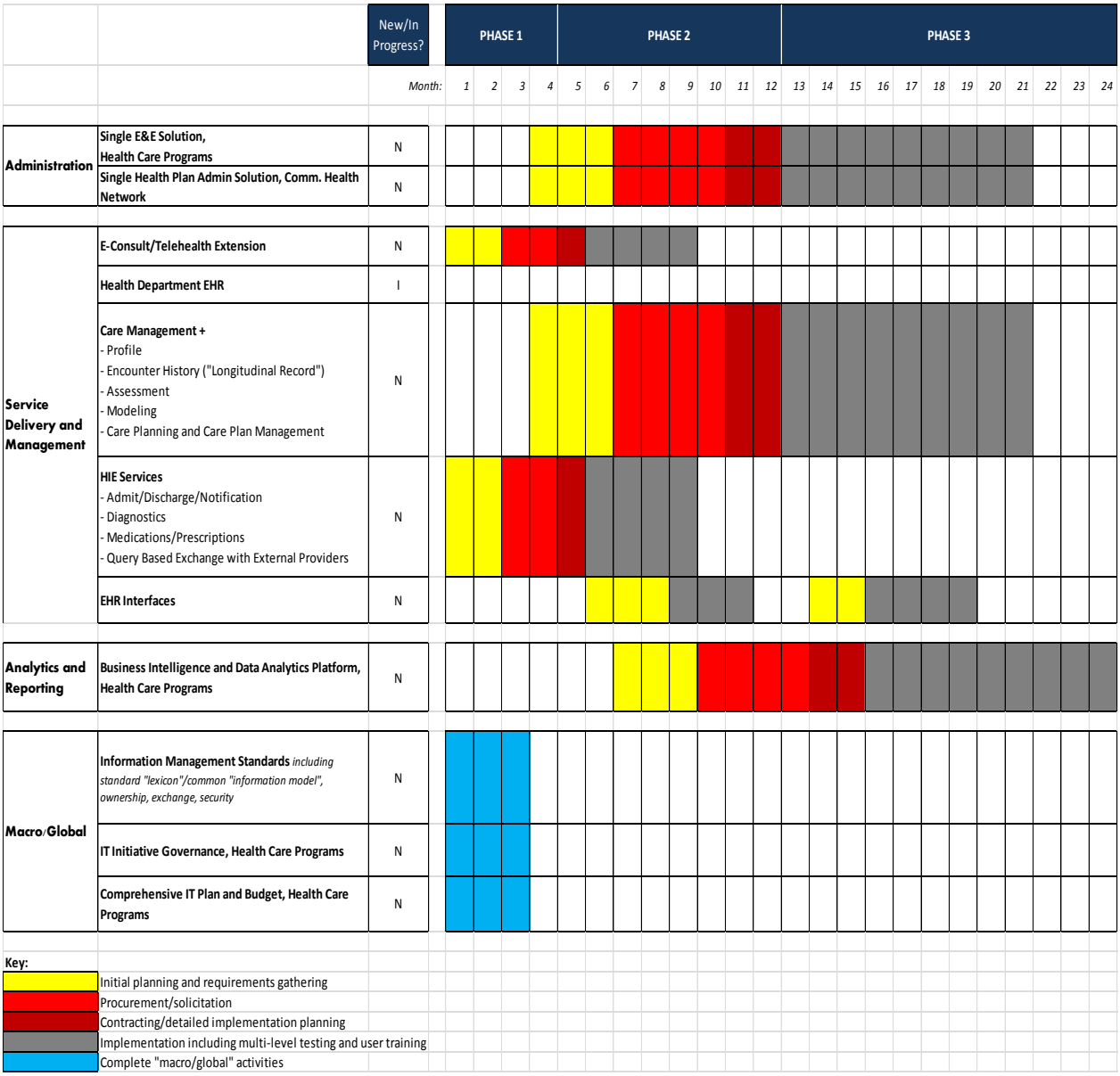
IT Recommendations: Initiative Sequencing and Relationships

HMA believes that there is a logical, optimal sequencing to these initiatives based on initiative interdependencies, the projected level of effort associated with each initiative, the cost of the initiatives and the potential short-term impact associated with some initiatives. HMA would advise the County to tackle these initiatives in accordance with a three-phase plan that would span as many as 24 months although it is possible that this time frame could be compressed if enough staff can be available to support multiple projects running concurrently and if the following issues do not become obstacles to rapid progress:

- The ability – at least in the short-term – to "piggyback" off existing solutions, e.g. some of the IT solutions that Molina has implemented within the CHCN program and clinics for care management, reporting and other functions;
- Requests for proposals, proposal evaluations and contracts;
- Data sharing agreements;
- Client consent laws and regulations;
- Cost allocation plans;
- Agreeing to and setting up data interfaces;
- Potential data conversion; and
- Existing projects such as the Health Department EHR and the ongoing implementations of the Credible solution within the CSB and the state's VaCMS application.

The proposed three-phase plan is shown in Figure 5.

Figure 5. Proposed IT initiatives in support of "new" Fairfax County safety net health care system



Best Practice Research and HMA Experience

Backing up HMA IT recommendations is a wealth of experience acquired through the health care restructuring projects it has led across the nation (some of which were profiled earlier in this report) as well as best practice research which we systematically conduct for multiple clients. Appendix F has examples of projects which demonstrate that our IT recommendations

are realistic and achievable: states and counties have pursued these successfully or are in the process of pursuing them. That noted, Fairfax County has an opportunity to build a model safety-net health care system powered by superior information technology; as such it will find that some of HMA IT recommendations may be "pushing the envelope". Nonetheless, it is HMA's belief based on deep understanding of the health care IT market that even the most ambitious IT recommendations are realistic given recent advances in the health care IT "state of the art". Examples are described in Appendix E.

Financial Opportunities to Support Integrated System

HMA is making finance recommendations to provide a source of financing for the start-up and implementation of the county-wide delivery network, Community Health Network, as well as other County priorities, including improving quality and/or accessibility of care. The recommendations are primarily reimbursement changes, many of which will require the cooperation of the State. While there should be no costs incurred by the internal reorganization of the Human Services System, there will be costs associated with establishing and maintaining the Community Health Network, the integrated delivery system of providers, including the County, Inova, Reston HCA, the FQHCs and others delivering care to the uninsured and Medicaid populations. Costs will include such infrastructure as Network staffing, eligibility and enrollment operations, care management, referral management, connective IT and other services necessary to assure seamless delivery of care. It is important to note that the establishment and operations of the CHN should be a shared responsibility among the participants. The recommendations below reflect those opportunities that could be realized through the County.

Finance Recommendations

The first set of recommendations require the cooperation of the State in making certain changes to Medicaid to allow Fairfax County and other counties to benefit from increased funding based on federal rules. While these recommendations will require the state's assistance they do not require any additional state funding.

On April 1, HMA met with Cindi Jones, the State Medicaid Director, and her staff (Cheryl Roberts, Bryan Tomlinson and two others) to discuss these recommendations. She and her staff were not very enthusiastic about any of the ideas except the housing recommendation (#9). HMA discussed with the County other administrative approaches to attempt to get these recommendations implemented.

Recommendations That Require State of Virginia Approval

1. **Claim federal match on all screening efforts for County programs**. The County should use Medicaid forms to screen everyone including those potentially eligible for Medicaid as well as those applying for County programs like CHCN. These efforts are matchable at a rate of 50% federal/50% state or local dollars based on doing the initial screening for Medicaid. The County would agree to provide the non-federal share for these payments via an Intergovernmental Transfer (IGT). In some states managed care plans have been willing to make contributions to this effort as they benefit from more people being

signed up. Further, hospitals, while having a $50,000 limit for contributions, may also choose to contribute. These contributions are used to decrease the County expenditure or increase the staffing available.

2. **The County should provide the State share to provide for the high end of Medicaid managed care rates to be used in Fairfax County.** Medicaid managed care rates are required to be actuarially sound. Actuaries normally do this by setting a range of rates for the population. The state typically pays the low end of the range. The MCO would agree to pay the County, as a provider, the additional amount generated by the County providing the match. This recommendation could result in significant revenue that could fund integrated delivery system activities and/or expanded services. Typically, this is a 4-6% add on which for 100,000 enrollees could add $500,000 per month in new net revenue.

3. **Medicaid managed care contracts allow the County to make a match from an IGT and claim the difference between the Medicaid payment and their full cost of the service including overhead**. There is at least one state that has set up their managed care contracts to allow for governmental providers to be paid at cost. The MCO first makes the normal Medicaid payment to the County provider. At the end of the year the County provider does a full cost report including overhead for Medicaid services provided to Medicaid clients and deducts payments received from the MCO. The County then makes the match for the state share of the difference and that difference is paid to the County provider. The managed care contract with the state would require the MCO to pay costs to governmental providers.

4. **The County should determine if there are opportunities for a "Nursing Home Upper Payment Limit" (UPL) payment by ascertaining how far the Birmingham Green facility payments are from the Medicare limit.** In some states this amounts to nearly $1 million new dollars per year. Again the County or in this case the Counties would pay the state share of the payment.

5. **The County should apply for an HCBS waiver that includes Assisted Living Facilities.** In at least one state, they have an HCBS waiver that includes Assisted Living Facilities. Assisted Living Facilities take both Medicaid recipients and private pay. Their current mix is 60% private pay/40% Medicaid. They have been very successful and a waiver of this type could increase the availability of these services in Fairfax County. If an HCBS waiver such as this is not possible, the County should at least get a Medicaid state plan amendment that would allow either that public assisted living facilities be paid cost, with the County paying the additional state share, or that private assisted living facilities

in Fairfax County be paid at a higher rate reflecting costs in the community, again with the County paying the state share.

6. **Evaluate Adult Day Care for being paid at cost for Medicaid in the same manner as the previous recommendation**.
7. **Consider working with the state and the managed care plans to pay a per member per month payment for school health services**, assuming that there is no Medicaid payment currently for school health services. The MCOs would pass the payments along to school health, assuming that the County pays the non-federal share with an IGT.
8. **Work with the State to gain federal approval of pilot programs with more robust services and payment streams in Fairfax County supported with County match**. The state is currently under pressure to deinstitutionalize Medicaid populations. Fairfax currently provides both HCBS and behavioral health services essential to achieving this goal. However, the reimbursement and available services are less than required to make this larger effort viable.
9. **The County should ask the State to request from CMS to allow Medicaid funding for housing bonuses to providers.** Historically, CMS has been unwilling to pay for housing services. The literature supports the fact that many populations -- severely mentally ill, substance use disorders, other disabled -- have lower health care costs if they have stable housing. One state is asking CMS to support stable housing bonuses for providers who keep a certain percentage of the individuals they serve in stable housing. Based on the high cost of housing in Fairfax County, this may be an option the County should work with the state to pursue. This initiative would help move more people from institutions to lower cost community settings.

Recommendations Not Requiring State Approval

1. **Explore the benefit of transferring specific services currently delivered directly by the County that are stand-alone services, not in a continuum of care, to private providers who may be better able to integrate those services in a more comprehensive way.** This action should be based on objective criteria that would demonstrate improved overall quality and potentially lower costs. If the County continued to pay a subsidy for these programs, it could use the subsidy to set rules on eligibility and incentivizing quality of care.
2. **Establish a County billing office that has high level Medicaid experience**. Medicaid represents a critical revenue stream that will become even more important over time.

The County needs expertise both in how to bill currently, and how new services need to be set up or existing ones modified to maximize reimbursement.

3. **The County should hire or contract with a Medicaid expert who can work with the County and State to maximize available federal programs to benefit clients clinically and the County financially.** There is a great deal of opportunity at the federal level and it is important to have access to a resource that is continually evaluating opportunities, both for the County or the community-wide network.
4. **Implement those recommendations in previous reports that would improve financial performance of Human Services System' agencies**. There needs to be a formal process, with staff reporting to the Deputy County Executive or her designee, to implement those recommendations or formally reject them based on sound reasoning that must be agreed to by the executive responsible for implementation.
5. **Consolidate all County pharmacy programs into one for efficiencies, with satellites in current locations**. The County should also explore whether they can become eligible for 340b or work with an entity that is so designated. 340b is a federal program that requires drug manufacturers to provide outpatient drug discounts to eligible providers. The savings potential in this area is significant.
6. **Consider attempting to extend the current agreement with Molina to continue to manage the CHCN clinics, as this relationship appears to be very successful**. Further, the County should accept Medicaid at their clinics to assure both access and continuity of care for this population. And, finally, the County should explore becoming a Federally Qualified Health Center look-alike, allowing the County to increase reimbursement for Medicaid patients and guarantee them access to 340b drug pricing. These actions—continuing the current role of the CHCN, beginning to accept Medicaid covered patients and securing the maximum reimbursement for these patients—are recommendations that should be discussed within the context of the CHN in order to assure that the securing of this additional primary care capacity for the target population, is supported by the entire network.

Communication Plan and Stakeholder Engagement

Fairfax County has asked HMA to assist with developing a communications plan to keep stakeholders informed and involved as the County embarks on both an internal reorganization and the development of a broader community-wide effort to create an integrated approach to the health care for its most vulnerable residents.

There are two primary activities that the County needs to communicate:

1. the consolidation of the programs and services directly related to patient care currently housed within the various departments of the Human Services System will be consolidated into one single "health care services department"; and
2. joining together with other community providers to create an integrated delivery system for low-income individuals (those who are uninsured and those who are on Medicaid).

HMA proposes a range of communication activities targeting internal County leadership and staff (County Supervisors, County Executive and other Deputies and County Departments, and senior Human Services leadership, program managers and front-line workers); critical community providers and stakeholders (hospitals, FQHCs, physician groups, social service providers, patient advocates, etc.); as well as the community at large. The activities will be planned in order to both inform and secure feedback about the plan and its implementation.

The strategy described below was heavily informed by the interviews that HMA conducted with almost 100 individuals (both internal to the County and from throughout the community) as well as by the experience gained through similar system transformation efforts in other communities across the country.

Messages

The critical message for the internal reorganization of County delivery system functions is that integration will: 1) produce a more stream-lined and efficient Human Services System, and 2) result in a more seamless system of care for those who rely upon the County for their healthcare services. Further, by integrating the direct care services into one entity, external providers can better partner with the County, which can now speak as one system of care, rather than multiple services and programs and departments.

The critical message for the establishment of a Community Health Network is that the effort will: 1) build an equitable, coordinated and financially viable approach to the care of all residents of the County for whom access is a problem, and 2) assure that all providers work together to minimize duplications and gaps in services.

Audiences and Strategies

County Human Services Staff and Advisory Bodies

County staff will need to be informed and involved in both the internal and external transformations and reorganizations. It is critical that they understand why these changes are needed, how the restructuring will result in better care for those that they are concerned with, what it means to them personally and as a particular program or Department. Successful change management requires both the mechanism for input and the assurance that leadership will make the change happen. Some have described the best way to assure participation is by making it clear that the transformation will occur so that it is to everyone's best interest to be actively involved ("if you are not at the table, you are on the menu"); however, it must be clear to all exactly what is happening and why. Further, the advisory bodies that have focused on these services and programs need to be informed about the work being undertaken.

Recommended Steps:

1. All Department leadership meets regularly with the Deputy County Executive to establish the timeline and specific tasks for the internal reorganization as well as the creation of the Community Health Network.
2. A clear set of "talking points" is created for all senior leaders within the Human Services System to serve as a tool for them to convey to their staff what is happening (both within the County and community-wide) and why.
3. Presentations are made by senior leadership regarding these plans at the relevant citizen boards that provide an advisory function to Human Services System activities, with a particular focus on those bodies that are directly impacted by the internal and external reorganizations. These presentations should focus on the value that both internal reorganization and participation in a broader community effort brings to those services that are the focus of the particular board.
4. A periodic update is provided (through written communication or in face-to-face forums) to all staff and advisory bodies about the plan progression.

Providers

Providers will be critical participants in the creation of the Community Health Network. It was clear to HMA in various discussions and interviews that there is a commonly held view that: 1) they each have critical roles in various aspects of the care of vulnerable populations; 2) there is little existing mechanism for common planning and communication among providers about who plays what role in the continuum of care; 3) the County is a major player but is seen as a series of individual programs and not one single system; 4) there has been enough planning and that there now needs to be a plan implemented; and 5) there is significant interest in

participating in a community-wide effort if that effort is designed around an equitable and transparent distribution of responsibilities. These issues must be addressed in an effective communication plan.

In addition, it is important to understand the individual issues facing the non-County providers that will be asked to come to the table.

- *FQHCs.* FQHCs are a very important part of the safety net for patients in the County (even though they are physically outside the County). They have co-located mental health and dental services. They receive higher Medicaid and Medicare rates for primary care, allowing further capacity to be developed for primary care. Health Works and ANHSI (Alexandria Neighborhood Health Services Inc) and Greater Prince William Community Health Center are the three FQHCs in the surrounding area that serve Fairfax low-income individuals. All three health centers operate with a payer mix that is at least twice the level of uninsured care as the national average; a level that is financially unsustainable. Despite their relatively low number of unduplicated patients (the County's CHCN cares for nearly the same number of patients as the FQHCs combined), they are a vital component of the network. There will need to be a strategy to increase the proportion of Medicaid-covered lives that have FQHCs as their primary care providers.
- *Hospitals/Health Systems***.** Inova is the largest hospital provider in the community with five hospitals serving parts of the County, and an increasing number of physicians as it purchases medical practices. The system also includes services for those with behavioral health problems and the fragile elderly and has made inroads in developing specific partnerships with individual providers. Reston HCA's uncompensated care burden has doubled in the last year, and several of its affiliated physician practices accept Medicaid so it has a role in providing care in the safety net. Kaiser accepts Medicaid patients in its managed care plan and participates with the County in critical service areas. The interest of Northern Virginia Medical Center should be explored. It is in the interest of all hospitals and health systems serving the County to participate in the development and maintenance of an integrated system of care, rooted in strong primary care, that integrates behavioral health, has clear management of patients away from hospital inpatient and ED services and is supported by connective IT.
- *Physicians and Dentists***.** Private physicians and dentists are providing some level of voluntary uninsured care and there are practices that are included in Medicaid networks. However, care is fragmented, referrals to specialty care are not consistently screened and connected back to primary care, and connections are not effectively made from the hospital back to the primary care home. The current access gaps for the

uninsured are likely to only further increase if Medicaid is expanded in Virginia and newly eligible people seek care. Specialty access is a current problem and can only be addressed by private—or employed—physicians.

Recommended Steps:

1. The Deputy County Executive for Human Services will convene a small group of the leaders of critical providers to discuss the development of the Community Health Network, as described above in this report.
2. That small group will, building upon past report, develop an initial outline for the CHN, including proposed roles of individual providers.
3. The public communication of this effort will be formulated by the group as a body, not as the County alone or as any one individual system.
4. The communications offices/people from each participating body will work together to fashion the public message about the creation of the CHN as a community-wide commitment.

Elected Officials

There is a great deal of interest in how local governments are addressing the health of their communities at all levels: county, state and federal. County governments are often seen as the "provider of last resort" but are also charged with overall "health of the public." States are concerned with assuring that there is access to health services that they fund through Medicaid and other programs. The federal government is promoting various strategies that assure "value" not "volume" of health care and is seeking innovation at the local levels that could promote the "triple aim" (higher quality, better health status, lower cost) and be replicated in other communities. The communication to public officials about the reorganization activities described in this plan should include all levels of government.

Recommended Steps:

1. The Deputy County Executive will brief all Supervisors, the Chief Executive Officer and the Human Services Council about the internal and external activities being undertaken to develop an integrated delivery system for vulnerable populations within Fairfax County. Talking points will be provided to these officials and offers made to more broadly discuss these efforts with various constituencies.
2. The evolving leadership of the CHN will take on the briefing of key State officials and legislators (including the Medicaid Director) about the effort to create a community-wide system of care that will have, it is anticipated, a positive impact on access to and quality of care for State-funded patients.

3. Efforts will be made to seek out critical federal officials in order to both inform of the efforts being made in Fairfax County and to identify potential areas of support (i.e., the Center for Medicaid and Medicare Innovation).

Key Community Leaders, Social Service Providers, Schools, Patients

In Fairfax County, even more than in most communities, it is critical to engage community leaders in the rationale for the process surrounding, and the results of reorganization and integration. In addition to the numerous boards and commissions discussed internal to the County, there is a solid group of individuals that have long-standing commitment to the provision of health care for the medically indigent. These people are resources and have a certain amount of influence with decision makers, the media, and the public. During the interview process, HMA met with many of these individuals and there are others—predominately business and faith leaders, social service providers, school officials—who were not interviewed but should be included in a broader communication plan. This communication should be varied as to form (i.e., presentations, social media, newsletters), but provided on an ongoing basis. It should be dependent upon the stage of the County reorganization and creation of the community network and adjusted to the issues at hand and the particular relevance to the target audience. Whenever possible—particularly when addressing issues related to the CHN—the communication should be developed and delivered by "partners," not just one participant.

Finally, but importantly, the communications strategy must include engagement of those that are using County services now and who will be using a new integrated, multiple provider network. County staff will develop patient education pieces for their own clients to describe the internal reorganization that will improve their experience and the new network communications group will take on patient engagement as the CHN comes into fruition.

Work Plan: Target Goals and Timeline

It is important that, in implementing the recommendations described throughout this report, a delicate balance is struck between the need to maintain active involvement of key stakeholders and the broader community while, at the same time, moving forward on a clear path, with specific benchmarks met and progress made. It is also critical to remember that the recommended implementation steps detailed in this document are facilitating a general direction that has been widely discussed, debated and, ultimately approved as the course that Fairfax County will take to achieve a transparent, cost-effective, transparent, equitable and high quality approach to assuring the health of all of the County's residents.

HMA believes that it is not only possible to achieve within six months at least the first steps toward both the internal and external reorganizations (and initial IT investments and finance strategies) described in this plan—it is also vital. The longer the effort drags on, the more that both internal and external stakeholders will be convinced that this is yet another report with little hope of implementation. There is appears to be widespread interest in making this happen now and it will be important to show progress quickly, even though the full reorganization is likely to take longer.

Timeline

There are several areas of work that should be initiated and occur concurrently; all of which should be overseen by the Deputy County Executive and a small **"Steering Group"** that should meet at least bi-weekly to assess progress and address and resolve barriers. There should be a **six-month** goal for this first round of activity, although it is acknowledged that full transformation (both within the County and for the external creation of a community-wide network) is likely to take 12-18 months.

The areas listed below should each have a County lead (person or persons) designated and accountable to the Steering Group. The tasks listed are summaries of the recommendations listed in the body of this report.

Creation of the Community Health Network

- Convene a small group of creative health care service provider leaders from within the Human Services System to develop the outline of a model for the Community Health Network, defining the population, identifying service and infrastructure gaps and centers of excellence for expansion (May).

- Secure the commitment of Inova, as the County's most dominant healthcare provider, to be an active participant in the network and work with them to produce an initial outline of the CHN (May).
- Convene a small group of community providers to initiate the concept of the Community Health Network (June).
- Determine priorities for specific County and community provider responsibility, financing priorities and an organizational structure for the CHN (September).
- Set a one-year implementation timetable for the CHN (September).

Internal Reorganization

- Assure all Human Service System departmental leadership fully understands the direction that the system is going and their specific roles in the reorganization (May).
- Begin the reorganization to create the new FCHS by identifying which services and programs should be included because of their role in direct care delivery (July), with the goal of having the new entity being in place by September.
- Identify all eligibility, enrollment and screening programs that should be consolidated into the new system-wide "front door function" and identify the appropriate leadership and structure (July).
- Evaluate potential consultants to assist in the creation of a more streamlined and effective "front door" (September) and have that assistance in place by September.
- Draft the job description for the Director of the new FCHS and assemble a small representative search committee (June) with the goal of having a Director named by August.
- Draft the job descriptions of the roles for a system finance director, with concentration on strategy and Medicaid expertise, and a system IT director to oversee implementation of the IT recommendations (June) with the goal of having these individuals named by July. (See specific IT and finance timeline below).
- Transition the Countywide Services Integration Planning program—and any other planning and evaluation services—into a system wide planning unit (September).
- Do an inventory of all current case management and care coordination currently existing within the Human Services System and establish a plan for integration (September).

- Evaluate, with the participation of key citizen leaders, the current advisory boards and committees that relate to the direct delivery of health care services to assure that they are organized in such a way to reflect the integration of these services (September).

Information Technology

- Identify a system finance director and establish a County IT work group including program people and clinical users (July).

- Determine the County IT priorities related to health service delivery (based on recommendations in the IT section) and identify which investments should be County-specific and which should be included as the infrastructure for the broader CHN network (July).

- Participate in a multiple-provider IT group assembled through the CHN process to set network priorities and resource allocations (July).

- Determine a clear set of County and CHN investments (September).

Financial Strategy

- Determine the County's strategy for seeking State cooperation in advancing revenue-generating strategies identified in this report (May) with the goal of advancing one or more such activity by September.
- Identify a system finance director with Medicaid strategic experience, and/or secure outside expertise in this area to oversee the implementation of any agreed upon strategies (July).
- Participate in a multiple-provider finance group established through the CHN process to set network finance strategies (August).
- Establish, within the new FCHS, a process to review all current County direct service delivery to assess the potential for more effective delivery of any such services through partnerships or contracts with third parties (October).
- Consolidate pharmacy arrangements operating throughout the County system (September).

- Establish a clear timeline for the implementation of financial strategies identified in previous reports on the Human Services System (June).
- Determine, through involvement in the CHN process, the appropriate ongoing role for the County in the operation of the CHCN, the potential for securing FQHC status and opening the clinics up to Medicaid patients (September).

Communications and Stakeholder Engagement

- Hold briefings of County Supervisors, all key advisory boards and all Human Services staff, with a common set of talking points, describing the reorganization process (April, May).
- Hold regular briefings throughout the next six months to assure that County staff and stakeholders remain informed.
- Convene, through the CHN process, a communications group from all participating providers, to develop and implement a consistent set of briefings and information (July).

Target Goals

It will be essential to show that there is real value in both the internal reorganization and the implementation of the Community Health Network as a County-wide strategy. Over the next six months, both the Human Services System and the CHN should identify target goals that they will monitor and report in an **Annual Report**—after one year and annually thereafter—to both the Fairfax County Board of Supervisors and the broader community.

The target goals should be chosen by the County and the CHN. Some examples of potential metrics utilized in other integrated delivery systems are listed in Appendix F.

Appendices

Appendix A: Fairfax County Health Collaborative Statutory Organizational Issues

Appendix A provides a summary of the key statutory and contractual considerations in designing a more integrated delivery system for Fairfax County. This summary focuses on the options for (1) organizing behavioral health services to increase access and coordination with physical health services and (2) the ability to create new organizations capable of integrating care and engaging private providers and academic health centers in a systematic approach to care delivery that better serves the needs of Fairfax County.

Issue: Organizational relationship of CSBs to other departments or county organizations

Under §37.2-500 et seq of the Code of Virginia, there appears to be no limitation on where CSBs reside in the county bureaucracy as long as it is consistent with the County ordinance creating them. Fairfax County-Falls Church CSB is an administrative policy CSB which means it is a government entity rather than an independent entity. This provides greater administrative discretion. That said, the statute requires that CSBs be the single point of entry for publicly funded behavioral health services. CSBs must retain the integrity of their organization. This means that they still have to report to a separate Board of Directors who appoints an executive director to administer them and report to the Board. It also means that they must conduct separate financial audits and adhere to their performance contracts with the Virginia Department of Behavioral Health to which they are directly accountable. These contracts are approved by the Fairfax County Board of Supervisors. Put simply, wherever the CSB is moved, it must be moved intact. The ways in which it provides services and the scope of its activities must be consistent with its performance contract with the state and the BOS ordinances creating and governing it. If the scope and manner of CSB services change, the state Department may need to approve amendments to the performance contract, and the BOS may need to issue a new ordinance. Because this is the Fairfax-Falls Church CSB, it is likely that there is an MOU with Falls Church stating the terms under which Fairfax will run the CSB. Therefore, any changes should be vetted against that MOU. It may be necessary to engage Falls Church in reforms related to the CSB.

Issue: Options/limitations for creating a separate public/private health organization to oversee and expand health care services to underserved populations

Sections 32.1-122.10:001-10.002 explicitly authorize local governments through ordinance or resolution to establish local health care authorities as joint public/private partnerships to encourage the use of private resources to help provide health services to underserved populations:

"A. Communities lack the ability to coordinate, across jurisdictions, health partnership efforts between local governments and private providers of health care services, which leads to duplicative and inefficient services. Such public/private partnerships could (i) encourage the use of service delivery that otherwise might have required government funding or programs; (ii) allow governments to fully participate in such partnerships; (iii) maximize the willingness of individuals, agencies and private organizations to lend their expertise to help satisfy community needs; (iv) allow innovative funding mechanisms to leverage public funds; (v) allow appropriate information sharing to ensure the adequacy and quality of services delivered; (vi) provide liability protection for volunteers providing services under programs sponsored or approved by the authority; (vii) provide a mechanism to ensure that services provided in the community are necessary, appropriate, and provided by trained and supervised persons; and (viii) allow volunteers and others to focus their energies to achieve community health improvement. Health care services include, but are not limited to, treatment of and education about acute and chronic diseases, wellness and prevention activities that promote the health of communities, and access to services and activities.

B. The governing body of a locality may by ordinance or resolution, or the governing bodies of two or more localities may by concurrent ordinances or resolutions or by agreement, create a local health partnership authority which shall have as its purpose developing partnerships between public and private providers. *The ordinance, resolution or agreement creating the authority shall not be adopted or approved until a public hearing has been held on the question of its adoption or approval.* The authority shall be a public body politic and corporate." [Emphasis supplied].

This clearly authorizes the county to create something like CHN and to integrate its services into it. However, §32.1-122.10:002 requires that the authority be governed by a board of directors in which citizens constitute the majority. Other board members must include at a minimum: one locally-elected official, one representative of the health care industry, one representative of the business community, and one representative of a nongovernmental human services agency. In order to maximize stakeholder engagement, the BOS could designate additional officials (such as members from multiple hospitals) to be on the board as long as citizens constitute the majority. The board appoints an executive director to administer the authority.

It is not clear that every private/public health partnership would be required to operate under this section. However, the language at the beginning stating that communities currently lack this ability and the strict requirements for public hearings suggest that this is intended as the primary vehicle for this type of collaboration, notwithstanding the fairly broad delegation of powers to county Boards of Supervisors. The legislature clearly anticipated that such an authority could potentially have substantial impact on a community. There is nothing that

would prohibit the CHN from being a purely private organization of providers, but that could limit the effectiveness of the integration envisioned. Because this vehicle would have substantial credibility, it may be worthwhile to pursue its feasibility with local officials.

Virginia statutes also permit the formation of health center commissions. However, these are intended to enable communities to acquire land and build health facilities (hospitals and health centers) through bond and other financing. Therefore, this vehicle does not appear to be relevant to the goals of this project.

Appendix B: Examples of Governance Reorganizations

Hennepin Health, Minnesota

Hennepin Health is a demonstration project started in 2012. It includes a hospital system, an FQHC, the county department of human services and public health, and the county health plan. Its goal is to integrate patients' medical, behavioral health, and social service needs. Community health workers conduct outreach and engagement. Patients are assigned to a multi-disciplinary team including a physician or nurse practitioner, a care coordinator, a pharmacist, a CHW, and others. The project has 6000 patients per month enrolled. The project has a shared savings component and voluntary partner withholds based on targets and risk taken on by each partner.

Genesee County, Michigan

Genesee County created a nonprofit private corporation to develop a health insurance plan for uninsured residents. The Board of Directors of the corporation consists of a county health officer, appointees of the Board of Supervisors, and hospital CEOs. This approach was supported by the three large hospital systems in the county, and private foundations contributed $1.7 million for infrastructure. DSH funding was maximized, and county voters approved a referendum to raise property taxes to bring $11 million in revenue to the plan. The business community was engaged to provide support for clinic operational infrastructure. The plan contracts directly with providers, particularly primary care providers, on a per member per month basis. The benefit package includes:

- Primary and specialist care
- Diagnostic services
- Prescription drugs
- Limited mental health benefits based on a payment of $600,000 from the Mental Health department to cover "less severe mental health patients" up to 20 visits.

Hospital care is not included in the covered benefit, but hospitals receive a payment from the plan to offset uncompensated care. The collection and publication of data that "tells the story" of the care provided is considered to be important to sustained support for the program.

Camden Coalition of Healthcare Providers, New Jersey

Since 2002, the Camden Coalition has been functioning as coalition of providers meeting to discuss issues they face practicing in Camden, New Jersey. As part of their work, the Coalition compiled a comprehensive database to analyze utilization of hospitals by Camden residents. They were able to identify the 13% of patients generating 80% of costs and the 20% of patients generating 90% of costs. The Coalition and the providers that participated in the coalition were

able to develop initiatives to address the health, behavioral, and social needs of those "high utilizers" to reduce their hospital and ED utilization. The Coalition built relationships with the provider community over its history that addressed the fragmented and episodic nature of care. Local hospitals, family physicians, internists, pediatricians, nurse practitioners, school nurses, physician assistants, and others have participated.

Portland, Oregon

The three County public health departments that make up the greater Portland area are members of the regional Coordinated Care Organization (CCO) that oversees the delivery of all health care, mental health and dental services to the Medicaid population. Enacted by the State legislature in 2011, the CCOs require the participation of public health departments as well as all providers that care for this population. There are 15 CCOs throughout the State, with the Tri-County Portland CCO the largest. The County health departments bring mental health services, some primary care capacity, and public/population health and prevention services to the networks. The CCOs are given a global budget from the State and are allowed to utilize funds for services that normally would not be covered by Medicaid but which are seen to contribute to effective health care delivery and enhancement (i.e., buying air conditioners for asthmatics). In the first 18 months of operation, the CCOs (statewide): decreased ED visits by 18%; decreased hospitalizations for chronic diseases from 14%-29% (depending upon the condition); and increased primary care access (enrollment in Patient-Centered Medical Homes up 36%, PCP visits up 18%).

San Francisco Department of Public Health

In 2013, the San Francisco Department of Public Health underwent a significant internal restructuring in order to assure that the various medical and behavioral health programs that it provided and funded (ranging from primary to specialty to inpatient to long-term institutional- and home-based care) functioned as an effective and seamless system of care. Previously all reporting separately to the Department Director, a new entity was formed, the San Francisco Health Network, and all medical services (including hospitals, clinics, community programs and jail health services) and behavioral health (mental health and substance abuse treatment) were consolidated into this new network. All care management, case coordination and utilization management was consolidated into a single function (the "Transitions Department") within the network. Connective IT is being developed to link the various programs (i.e., patient registry, empanelment tools). The network is functioning as a consolidated entity in working with health plans and other community partners.

Orange County, California

Like Fairfax County, Orange County is an affluent county with pockets of substantial need, including nearly 350,000 uninsured, only half of which are anticipated to gain Medicaid or private insurance coverage under ACA. To consolidate resources and ensure maximum allocations for care delivery, the County's Health Services Agency created an Office of Integration that operates across the various components of the public health system and reports directly to the Board of Supervisors. It focuses particularly on coordinating mental and physical health services and aligns strategies. Funds are pooled across departments to fund care for the uninsured. This centralization is accompanied by a public/private partnership to leverage the Community Benefit strategies of nonprofit hospitals. In addition, tobacco money and county resources were leveraged to enhance DSH funding for county health services. Finally, enrollment and eligibility services were streamlined to include the following features to ensure prompt delivery of services with first patient contact:

- Point-of-service enrollment at clinics using Medicaid application to achieve Medicaid enrollment where possible;
- Presumptive eligibility for 3 visits which provides time to provide documentation for eligibility determinations while addressing immediate health care needs;
- Interconnected IT system for eligibility and enrollment; and
- Safety Net Connect system for a web accessible, cloud based HIT solution linking all community providers.

San Mateo County, California

In 2008, San Mateo County undertook a full reorganization and consolidation of its health services and population health programs across previously disparate agencies. The primary, specialty, inpatient, mental health, long term care, and public and population health were consolidated into one entity. Key staff across the agencies participated in the planning based on a commitment that the efficiencies (and any resulting staff losses) would be distributed equally across agencies. Savings were re-directed to services.

New York City, New York

New York City consolidated its mental health department with its physical health department creating a unified Department of Health and Mental Hygiene. A separate Commissioner of Mental Hygiene was appointed within the Department, a position designed to maintain the level of effort for mental health services. Operations but not programs were merged, generating operational and IT savings.

Mecklenburg County, North Carolina

Starting in July 2013, Mecklenburg County's public health department will once again be run by the county after being run by Carolinas HealthCare System for 18 years. It provides a wide variety of services, including flu shots, cancer screenings and health care in Charlotte-Mecklenburg schools.[4] Since the mid-1990s, the county paid Carolinas HealthCare to provide hospital services for the poor, mental health services at CMC-Randolph (behavioral health hospital), and public health services. In 2011, the county decided it was paying too much for poor and mental health services, so decided to bring these services in-house. While the County does not provide primary care services, it does offer WIC, family planning, immunizations, STD and TB treatment, women's health, including mammography and Pap smears, and a variety of other services or on a sliding scale fee, and School Based Health Clinics. [5] The county also has a separate Health Informatics division that manages medical records. [6]

Access to care has been identified as a priority area in the most recent CHNA (2010) and recommendations include to increase the number of Federally Qualified Health Centers (FQHC). Outside of the two hospital systems, the safety net system in Mecklenburg is comprised of one federally qualified community health center, seven free clinics, Carolinas Medical Center Ambulatory/Community Care Clinics (4), Volunteer physician care for the low-income uninsured program: Physicians Reach Out (administered by Care Ring), A Community Pharmacy: MedAssist, and a county-owned behavioral-health hospital. The county has a program called Medlink, which is a formal network of the local health care safety net organizations that provide or support the delivery of health care services that serve to connect residents to free or low cost services.

The School Health Committee is consolidated within Charlotte Mecklenburg Schools.

[4] http://wfae.org/post/mecklenburg-county-hopes-public-sees-no-changes-public-health-changeover
[5] http://charmeck.org/mecklenburg/county/HealthDepartment/AboutUs/Documents/MCHDAnnualReport.pdf
[6] http://charmeck.org/mecklenburg/county/HealthDepartment/AboutUs/Documents/HealthOrgChart.pdf

Appendix C: List of People Interviewed

Community Stakeholder/ County	Interviewee
County	Patricia Harrison Deputy County Executive for Human Services
County	Sharon Arndt (Partnership for Healthier Fairfax, Community Transformation Grant)
	Jesse Ellis Administrative, Policy, and Strategic Initiatives Coordinator, Office of the County Executive
Human Services Administration	M. Gail Ledford Director
	Inez Frank Division Director, Human Resources
	Lee Ann Pender Division Director, Contracts Management
	Ron McDevitt Division Director, Financial Management
	Ferdous Hakim Division Director, Physical Resources and IT
	Brenda Gardiner Policy and Information Management
County – CSB	Daryl Washington Deputy Director Fairfax-Falls Church Community Services Board
	Laura Yager Director of Partnerships and Resource Development
	Ginny Cooper Manager, Fairfax Falls Church CSB
	Dr. Colton Hand CSB Medical Director
	Louella Meacham CSB Director of Nursing
	Florence Hagan Behavioral Health Nursing Supervisor, Alcohol and Drug Services, CSB
	George Braunstein Executive Director (retired), Fairfax-Falls Church Community Services Board (Principal, leadership team)
	Lisa Potter Director of Strategy and Performance Management
County – CSB	Kaye Fair Mental Health Division Director, CSB
Community Stakeholder – CSB	W. Kenneth Garnes Chair, Fairfax-Falls Church Community Services Board

Community Stakeholder/ County	Interviewee
Community Stakeholder – CSB	Katherine K. Hanley Former Chair of Board of Supervisors, Former Secretary of Commonwealth, Member, Fairfax-Falls Church Community Servicers Board
County – CHCN	Arsenio DeGuzman Program Manager, Community Health Care Network, Fairfax. Co. Health Dept.
County – CHCN	Robin Mullet Assistant Program Manager, CHCN
County – CHCN	Dr. Jean Glossa Molina Health Systems, Director Fairfax County Community Health Care Network
County – DFS	Nanette Bowler Director Department of Family Services
	Juani Diaz Program Manager, Self-Sufficiency Programs, Department of Family Services
County – DNCS	Chris Leonard Director, Department of Neighborhood and Community Services
	Sarah Allen Division Director, Access Services, Dept. Neighborhood and Community Services
County – DNCS	Michelle Gregory Division Director, Countywide Services Integration, DNCS
County – DoH	Dr. Gloria Addo-Ayensu Director Fairfax County Health Department (Principal, leadership team)
County – DoH	Raja'a Satouri , M.D. Deputy Director for Medical Services
County--DoH	Rosalyn Foroobar Deputy Director for Health Services, Fairfax. Co. Health Department
	Michelle Milgrim Director of Patient Care Services
County – Long term care	Bob Eiffert Long-Term Care Program Manager, Fairfax. Co Health Department
	Barbara Antley Director Fairfax County Adult and Aging Services, Dept. Family Services
	Mathew Barkley Director, Disability Planning Services Development , Dept. of Family Services
	Susan Shaw Management Analyst, Health Dept.
County – Finance staff	Financial Management Team: Ronald McDevitt Marijke Hannam,

Community Stakeholder/ County	Interviewee
	Michelle Wilhelm, Dana Thompson, Valecia (Lisa) Witt, William (Bill) Belcher, Patty Yates, Kerry Muccino , John Simmons
	Program/Project Staff: Brenda Gardiner, John Ruthinoski
County – IT staff	Karen Field IT Program Manager, Dept. Information Technology
	Greg Scott Information Technology Program Director, Dept. Information Technology
	Department IT and Program Managers: Pam Cole, Rick Dumas, Liz Henry, Mary Walker, Alyson Peirce, Ferdous Hakim, Nikki Thomas-Campbell, Michael Snider, Greg Scott, John Ruthinoski, Jerome Newsome, Victoria Cardoza
County – Board of Supervisors	Sharon Bulova Chair, Fairfax County Board of Supervisors
County – Board of Supervisors	Catherine Hudgins Supervisor, Fairfax County Board of Supervisors
County – Board of Supervisors	Penelope Gross Supervisor, Fairfax County Board of Supervisors
Provider	Knox Singleton CEO, Inova Health System
	Karen Berube Assistant Vice President, Inova Health Systems
	Jennifer Siciliano Vice President, Government Relations, Inova Health Systems
Provider	Dr. Loring Flint Exec. VP Pres. And Chief Medical Officer at Inova Fairfax Hospital Inova Medical Group
Provider	Robert Cates, MD Chairman, Emergency Services, Inova- Fairfax Hospital
	Glen Drukenbrod Medical Director
Provider	Robert Hager Assistant Vice President, Long Term Care Services, Program Director, InovaCares for Seniors
Provider	Rich Leichtweis Inova Kellar
Provider	Carol G. Jameson, MSW Associate CEO HealthWorks for Northern Virginia
Provider	Debra Devar Executive Director, HealthWorks for Northern Virginia

Provider	Martha Wooten Executive Director, Alexandria Neighborhood Health Services, Inc.
Provider	Rose Ann Eapen, M.D. Volunteer chair of Medical Society of No. Va. Pro-bono specialty care - (Project Access of Northern Virginia - PANV)
Provider	Robert L. Phillips, Jr., MD MSPH Vice President for Research and Policy American Board of Family Medicine
Provider	Tracey White, VP, Community & Government Relations HCA Virginia Health System - HCA Capital Division Julie Widman, Director, Case Management Ryan DeWeese, Assistant Administrator, HCA Reston Hospital Cindy Glover, Chief Nursing Officer Ben Brown, Associate Chief Operating Officer, HCA Reston Hospital
Provider	Tom Wilson Executive Director, Northern Virginia Dental Clinic (also supports Mission of Mercy annual project at Northern Virginia Community College)
Provider	Dr. Howard Kelley Northern Virginia Community College, Director, Restorative Clinic
Health Plan/Provider	Russell Mohawk Senior VP and Interim CEO, Population Health and Health Outcomes, In Total
	Karen Berube Assistant VP, Population Health Management, Inova
Health Plan	John Muraca CEO, INTotal Health
	Sheila Owens, MD, CMO
	Cheryl Riscciardi, VP Clinical Affairs
	Jeannine Woldt, Chief Administrative Officer
Provider/Plan	Kaiser Permanente:
	Mindy Rubin Community Benefits Director
	Sarah Eissler Executive Director, Mobile Medical Services
	Kimberly Fox MCCP Kaiser and Bridge program
	Maritha Gay
	Loan Nguyen, M.D.
	Christopher Dellasantina, M.D.
Health Plan	David Natarai CEO, Innovation Health
State – Medicaid Director	Cindi Jones Medicaid Director for the State of Virginia
	Cheryl Roberts
	Bryan Tomlinson et. Al.

Community Stakeholder	Verdia Haywood Former Deputy County Executive, Fairfax County Government (also member of Fairfax County Long Term Care Coordinating Council, board member Northern Virginia Health Foundation (and others)
Community Stakeholder	Marlene Blum Chair, Fairfax County Health Care Advisory Board
Community Stakeholder	Mary Agee President and CEO of Northern Virginia Family Service (also Inova Health Care Services Board of Trustees)
Community Stakeholder	Cyndy Dailey Director, Health and Mental Health Services, NVFS
Community Stakeholder	Patricia Mathews President & CEO Northern Virginia Health Foundation (member Fairfax County Health Collaborative)
Community Stakeholder	Greg White, MSW Chief Operating Officer, Cornerstones
Community Stakeholder	P.J. Maddox, Ed.D. Chair, Department of Health Administration and Policy, George Mason University (Inova board member)
Community Stakeholder	Len Nichols, PhD. BMU and HSS/CMS Innovation Grant Fellow; advisor to The Commonwealth's Health Reform Initiative (wrote GMU report)
Community Stakeholder	Ann Zuvekas Member, Fairfax County Health Care Advisory Board
Community Stakeholder	Keith Hearle Verité Healthcare Consulting, LLC (ANHSI Board of Directors; contractor for Inova Health Systems Community Needs Assessment)

Appendix D: Direct services to explore consolidating

(Agency/program in County department and/or contract funds)

Direct Operations (staff support and operations funding)

Fairfax-Falls Church Community Services Board

Care Coordination/Case Management for Older Adults with Disabilities

Health Department Maternity Services

HIV/AIDS/Ryan White Services (including Inova Jupiter)funding)

Long Term Care Facilities (Lincolnia and Braddock Glen)

Medicaid Waiver Services

Medical Care for Children Partnership

PACE

Adult Day Health Services

Adult Health Partnership

Contributory Agencies

Birmingham Green

Under Contract

Community Health Care Network

Culmore Clinic

Senior Plus

Youth and family behavioral health contract services – (DFS/CSA)

Funding for:

Alzheimer's Family Day Center

CrisisLink

Homeless Medical Services Program

Northern Virginia Dental Clinic

Northern Virginia Family Service Multicultural Human Services

Northern Virginia Family Service – Patient Assistance programs Northern Virginia Specialty Access Program

Appendix E: Examples of IT Infrastructure for Restructuring Projects

Hennepin County – Integrated Eligibility and Enrollment System

Much like Virginia, Minnesota is a state where its 87 counties have direct responsibility for eligibility determination and facilitation of enrollment into multiple health care programs including Medicaid. Hennepin County, the most populous county in the state which includes the city of Minneapolis, has always seen itself - and has been regarded by other counties in the state - as a leader in the use of IT to improve its operations. Moreover, looking ahead to health care reform the county established a managed care organization – Hennepin Health – that brought together all of its safety-net providers.

Beginning in 2007 Hennepin embarked in an initiative that consolidated eligibility determination and enrollment functions for all County financial, social, and health care service programs under an integrated model which became known as the *Client Service Delivery Model (CSDM)*. The model incorporates four main functional areas:

- Initial contact and screening;
- Eligibility determination and in-depth assessment;
- Case management and
- Ongoing services and supports.

A critical IT component of the CSDM is the County's *Enterprise Communication Framework (ECF)*, a secure web-based content and process management application that links together workers, systems, cases, clients and information. Within ECF:

- Information is stored electronically in a central location. Workers can access ECF to learn when multiple service areas are working with the same client;
- Eligible workers can access state IT systems to view client or case related information;
- Mobile workers can access, review—and share—client or case related information using a secure communication method. Workers can review documents on-line with case workers;
- Clients only have to provide most documents once and their workers will be better able to view existing information needed to provide answers quickly and accurately; and
- System and content access is regulated to comply with data privacy laws and best practices.

Within ECF also provides for a single, shared, accessible "electronic case file" for all clients served by the County across fifteen service lines.

An interesting challenge which County staff raised about the implementation of CSDM was an internal one: the view held by some staff regarding professional specialization versus generalization, i.e. "I am not a generalist social worker, I am a child protection or crisis services or adult mental health or whatever other specialty social worker." Change management was critical to ensuring that staff accepted new roles and responsibilities; staff who initially seemed resistant to altering their work practices became some of CSDM's strongest supporters once they understood the purpose of the model and how they could contribute to its implementation for the benefit of clients.

Missouri Medicaid Health Homes – Longitudinal Record and Care Management Facilitation

In Missouri, the state deployed the *CyberAccess* solution, a a web-based longitudinal person record that captures data for MO HealthNet, the state's Medicaid program, and is accessible to enrolled Medicaid providers, including community mental health centers (CMHCs), primary care practices and schools. The tool is a HIPAA-client portal that enables providers to:

- Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
- View dates and providers of hospital emergency department services;
- Identify clinical issues that affect an enrollee's care and receive best practice information;
- Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
- Electronically request drug prior authorizations or clinical edit overrides;
- Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice;
- Electronically request pre-certifications for inpatient services, diagnostic imaging services and durable medical equipment;
- Review laboratory data and clinical trait data;
- Determine medication adherence information and calculate medication possession ratios; and
- Offer counseling opportunities for pharmacists through a point-of-service medication therapy management module.

The state also maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. The state is currently working towards developing capacity for a daily data transfer listing all new hospital admissions discharges. This information will then be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a Health Home. The contractor will then immediately notify the health home provider of the admission, which in turn will enable the health home provider to locate and engage persons in need of health home services; perform the required continuity of care coordination between inpatient and outpatient; and coordinate with the hospital to discharge and avoid readmission as soon as possible.

Moreover, health home providers have access to an application that supplies care management "to-do lists" to aid the providers with care coordination activities. Additionally, Missouri is trying to create an immediate notification system so that when a person a pre-certified for hospital admission, the health home CMHC is notified so they can follow-up and facilitate comprehensive transitional care services.

The above functionality which is already available to providers is complemented by requirements of all health home providers to utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning. Providers are also expected to routinely access a behavioral pharmacy management system to determine problematic prescribing patterns

Finally, as a means to engage health home enrollees in the management of their care and the promotion of health, CyberAccess offers "personal health record" functionality including but not limited to:

- Claim/encounter data for the past three years;
- Cardiac and diabetic risk calculators;
- Chronic health condition information awareness;
- A drug information library;
- An online tool for creating a personal health plan; and
- Discussion lists to use with healthcare providers

D.C. Medicaid Health Homes – Cohesive HIT/HIE Solution

A team from HMA has been working for about a year with the District of Columbia's Department of Health Care Finance (DHCF) and Department of Behavioral Health (DBH) to design and implement a Medicaid health homes program designed to address the needs of individuals with both behavioral health needs and chronic physical illnesses. As part of this effort we assessed the capabilities of existing information systems in the District and articulated a target IT architecture (refer to Figure 6) for this program that incorporates the following information technologies/systems:

- The Integrated Care Applications Management System (iCAMS), the instance of the IT solution developed by Credible Wireless which was acquired by DBH in 2013, which could serve as the core component of a comprehensive *HIT/HIE solution* for the program particularly since, initially, providers that will be required or expected to use iCAMS (e.g. the "core service agencies") will also be serving as health home providers.
- eClinicalWorks (eCW), the EHR which the District's FQHCs have adopted with the support of the District's Department of Health (DOH). eCW is being accessed by FQHCs on a "software as a service" basis, which reduces implementation, operations and maintenance costs.
- Direct Messaging. As part of DC-HIE, the District-wide HIE initiative managed out of DHCF, Direct provides the capability to exchange hospital admission, discharge and transfer (ADT) data and clinical care documentation in summary form via secure e-mail; these data could be "decoded" and uploaded to EHRs equipped with this ability. Alternatively the Direct messages can be accessed by providers outside of their EHRs.
- The Encounter Notification Service (ENS) offered by the *Chesapeake Regional Information System for Our Patients (CRISP)*, Maryland's HIE initiative, in partnership with DC-HIE. This service will enable health home providers to receive real-time alerts when one of their clients accesses an emergency room in a District or Maryland hospital or is admitted or discharged from one of those hospitals. ENS can be extended to trigger notification when clients visit certain physicians. Currently CRISP receives information pertaining to all ER visits and inpatient admissions from participating hospitals. CRISP has the ability to communicate this information, in the form of real time hospitalization alerts to PCPs, care coordinators, and others responsible for patient care. The operation of ENS is illustrated below (Figure 7; figure provided by CRISP).

An HIT/HIE solution which is feasible for go-live may not have the full functionality or "integrability" of a longer-term solution that could be deployed by taking full advantage of the information and functionality which would be available out of DOH, DHCF, the District's

Department of Human Services (DHS) and other District entities. Significant effort may be required to either build or customize existing functionality and to build the requisite interfaces to facilitate the movement of information between health home providers and these entities.

Figure 6. Proposed IT architecture, District of Columbia Medicaid Health Homes program

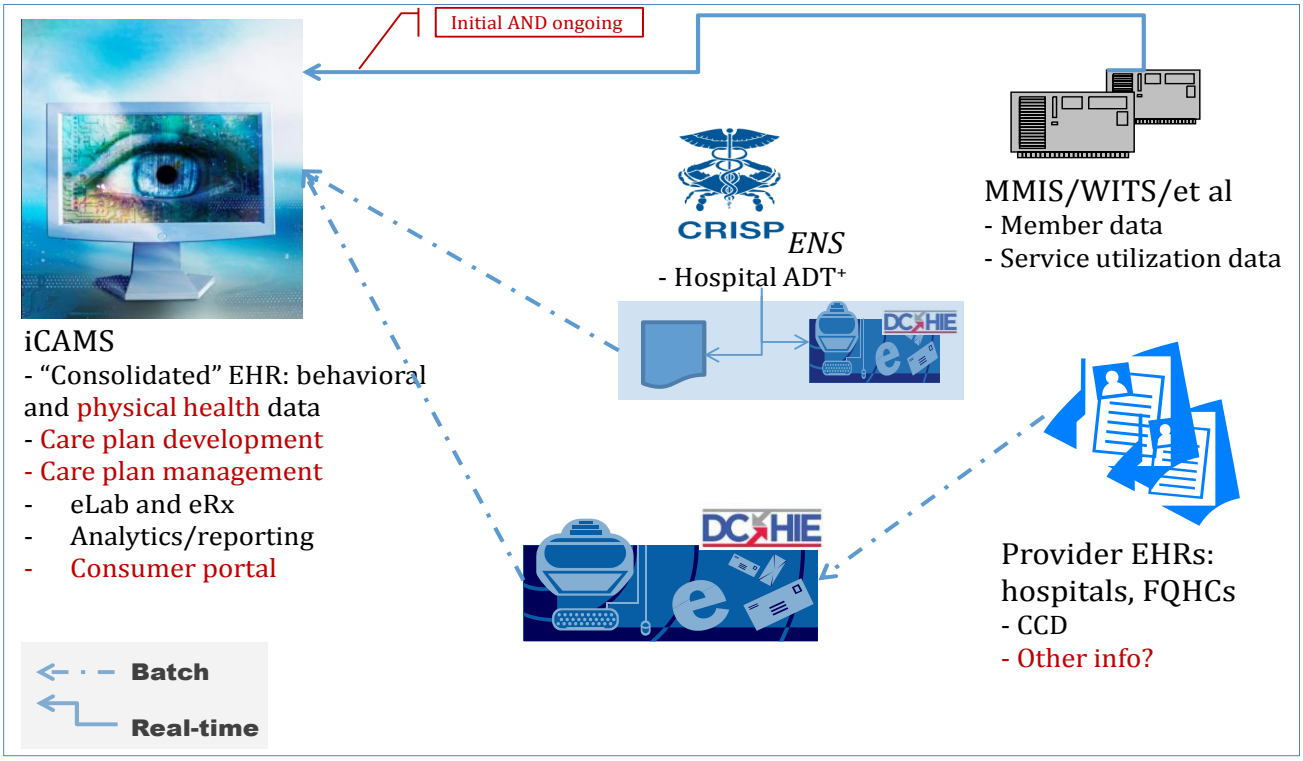
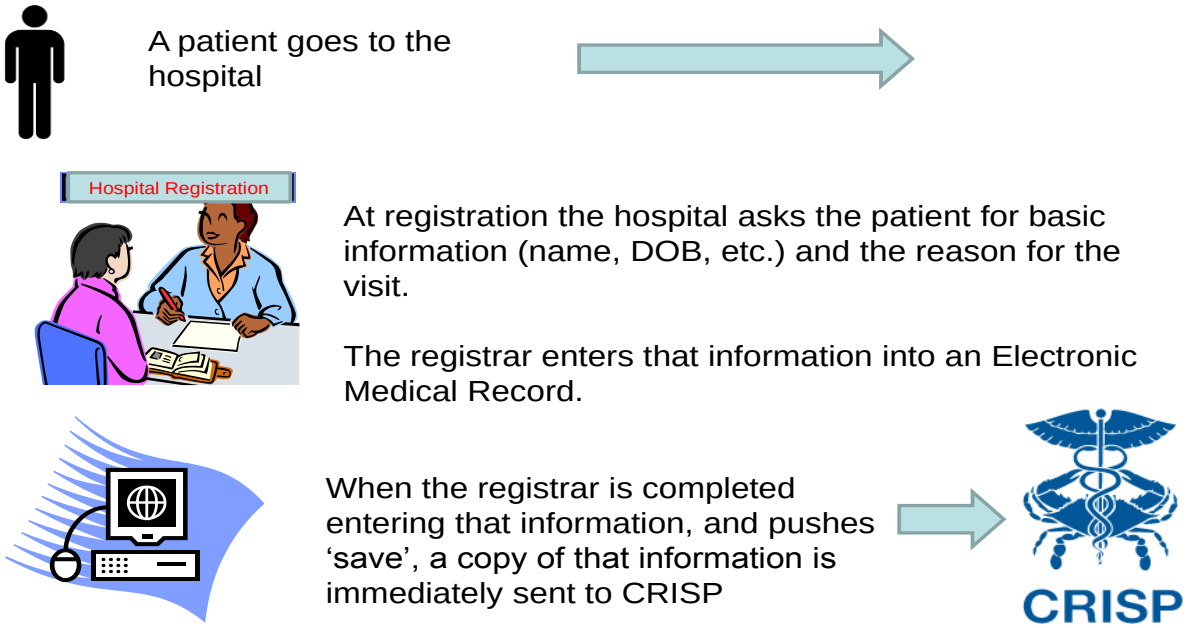


Figure 7. Visual description of CRISP Encounter Notification Service (ENS)

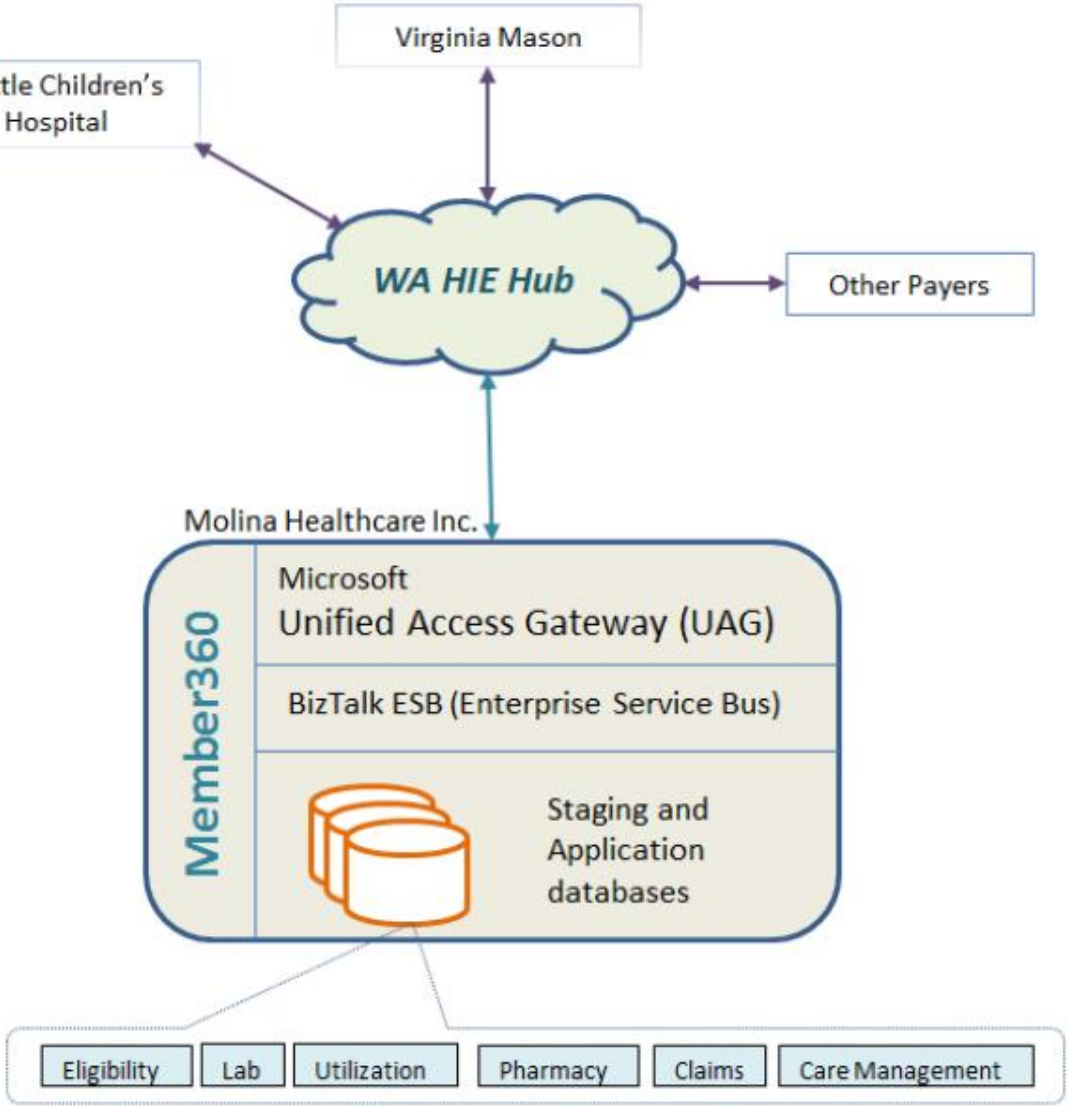


Molina Washington State - Health Information Exchange

In the state of Washington, Molina partnered with WA HIE, the state's HIE, to set up an HIE gateway for Molina's network providers. This solution, illustrated in Figure 8, leverages Molina's HIE solution code named Member360. This enables Molina to share member clinical information with the state Medicaid agency and with select providers. Furthermore, Molina is already receiving HL7-compliant Admit and Discharge notifications from Seattle Children Hospital and Virginia Mason Hospital. The functionality of this solution is expanded to incorporate other high-value health data such as lab results, medications, immunizations and diagnostic results.

The architecture of this HIE solution is illustrated in Figure 8.

Figure 8. Architecture of Washington State Molina HIE Solution



Appendix F: Potential Target Goals

Target Goals	Percentage
Percent of providers that meet patient panel goals.	
Percentage of patients who are provided access as designated in system standards (eg. Initial visit within 30 days, specialty referral within 30 days, phone calls or messages provided successful response)	
Percentage of successful phone call from designated providers practice within 48 hours of an ED visit discharge.	
Percentage of inpatient discharge provided transitional care package (primary care appointment within 7 days, phone contact within 48 hours of discharge, medication reconciliation within 7 days, counselling on red flags within 7 days, inpatient discharge summary received within 7 days)	
Percentage of adolescent to adult patients who received screening package within 1 year (Depression, smoking, substance abuse, domestic violence, pap smear and Hepatitis C if appropriate)	
Percentage of adolescent to adult patients who are entered into care for conditions identified at screening.	
Percentage of patients with chronic conditions who have a shared care plan.	
Percentage of asthmatics on an inhaled corticosteroid.	
Cost – Percent change in per capita cost of individuals in the CHN network	
Comprehensive Diabetes Care [Hemoglobin A1c (HbA1c) testing, LDL-C screening and Medical attention for nephropathy only]	
Percent of eligibility cases processed within x period of time	
Percent increase in volume of visits E.g., primary care (adult, geriatric, peds), specialty care, wellness, screenings, etc.	
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department (ED) Visit	
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	
Follow-Up After Hospitalization for Mental Illness	
Percent reduction in inappropriate utilization of the ED	
Percent reduction in admission for ambulatory care sensitive conditions	
Percent reduction in readmission within 30 days	
Percent of specialty visit referrals that were appropriately screened	
Percent of specialty visit patients who are returned to their primary care doctor	
EBPs shared across system with joint monitoring of health conditions for selected individuals	
Consistent set of screening tools across disciplines which guide treatment	

Target Goals	Percentage
interventions	
Percent increase in payments received from payers, i.e. Medicare, Medicaid, other sources.	
Percentage of uninsured treated by network	
Percentage of individuals under 200% FPL treated by network	
Percentage of first-time individuals referred/enrolled into coverage	
Health Status: Percent change in individuals with 2 or more chronic conditions	
Health Status: Percent change in individuals with diagnosed mental illness	
Percent increase in number of people seen in clinical setting within 3 days of initiating contact)	
Medication Management for People with Asthma	
Antidepressant Medication Management	
Childhood Immunization Status	
Percent of health visits where patient is also seen by behavioral health provider	
Percent of behavioral health visits where patient is also seen by primary care provider	
Percent of primary care visits provided in a patient centered medical home	
Percent increase in collaborative treatment planning for shared individuals	
Staff actively identify system solutions together (to reduce system barriers) and/or develop workarounds to resolve	
Percent increase in people enrolled in Medicaid/Marketplace	
Proportion of costs spent on administration	
Percentage of staff using single entry point for access client information	