JCHC Workplan

Commission Meeting
May 18, 2022

JCHC workplan includes four primary staff studies

- Affordability of assisted living facilities
- Reducing unnecessary emergency department utilization
- Structure and financing of local health departments
- Provider data sharing to improve quality

Affordability of Assisted Living Facilities

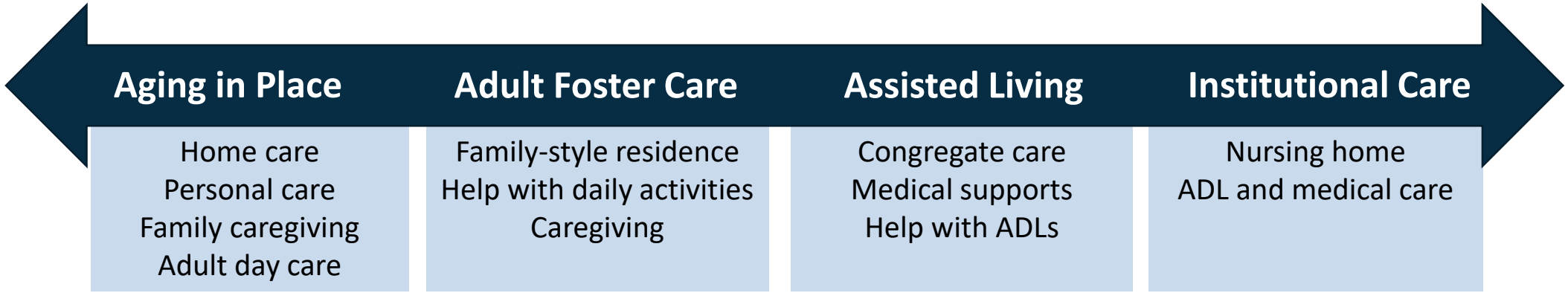
Analyst: Estella Obi-Tabot

Study purpose

- Identify challenges ALFs have accepting AG residents
- Assess key factors contributing to AG bed availability
- Assess whether residents may be more appropriately served in other settings
- Understand different ways states structure and finance ALFs and assess the feasibility of those models

AG = Auxiliary Grant
ALF = Assisted Living Facility
Study mandate approved by the Commission on December 07, 2021

Assisted Living is a community-based residential setting with ADL supports



ADL = Activities of Daily Living

The assisted living population has low-moderate functional needs

- ALFs are non-medical, residential settings that provide or coordinate personal and health care services
- ALF residents are typically no longer able to live independently, but do not require NF level of care
- In some instances, ALFs can serve as an alternative to a nursing home to help people maintain independence

SOURCE: Department of Social Services – Standards for Licensed Assisted Living Facilities
NF = Nursing Facility

ALFs vary significantly in size and the type of services provided

- Capacity ranges from 3-500 residents
- 572 Total Licensed ALFs
  - **79 Residential Living** ALFs serve lower need residents who need minimal ADL or medication assistance
  - **493 Assisted Living** ALFs serve higher need residents who typically need support with at least two or more ADLs

NOTE: Assisted Living Care ALFs include ALFs that serve residents with a primary psychiatric diagnosis of dementia.

The average cost of assisted living in Virginia is $5,250 per month

- Most residents pay for ALFs with retirement earnings, LTC insurance, or family support
- Individuals with limited income and financial resources may be eligible for the Auxiliary Grant program

SOURCE: 2022 Genworth Cost of Care Survey
LTC = Long-term care

Auxiliary Grant program supplements SSI payment for eligible individuals

- Individuals must live in an ALF, adult foster care, or other supportive housing setting
- The AG population is 8% (3,013 recipients in FY21) of the total ALF population, and 220 of the 572 ALFs accept AG
- AG program appropriations are $26.4 million in FY22
  - 20% local match in addition to state general funds

Multiple state and local agencies oversee ALFs and AG program

- **DSS** staff license and regulate ALFs
- **DARS** administers the Auxiliary Grant program
- **Local DSS** complete eligibility screenings and process AG payments to ALFs

DSS = Department of Social Services
DARS = Department for Aging and Rehabilitative Services

Major study questions

- What is the actual number of AG beds available in Virginia, and where is the access most limited?
- What are the typical needs of ALF residents, and are there other settings more appropriate for them?
- How does Virginia's SSI supplement (AG program) compare to other states?
- How are states using Medicaid to pay for services in ALFs?
- Are there other models to fund ALFs Virginia should consider?

Research methods

- Analysis of program data from DARS, DSS, and DMAS
- Survey of ALF Administrators
- Site visits with ALFs, Adult Foster Care, and other supportive housing settings
- Interviews with state experts and staff

Reducing Unnecessary Emergency Department Utilization

Analyst: Stephen Weiss

Study purpose

- Research and report on emergency department (ED) trends and utilization
- Evaluate how health coverage and access to primary care may effect ED use
- Assess impact of free standing emergency departments (FSED) on ED utilization
- Identify options to reduce “unnecessary” use of EDs

NOTE: Study mandate approved by the Commission on December 7, 2021.

ED utilization has been an ongoing concern for the General Assembly

- Recent legislation to address ED use includes:
  - 2020 budget language directed a DMAS Workgroup to report on ED utilization and free standing emergency departments
  - 2020 budget language authorizes the review and reduction of certain avoidable ED claims for Medicaid reimbursement
  - 2022 legislation (HB910) requires hospitals to report ED visits by evaluation and management codes to VDH

There were 3.1 million patient visits to Virginia EDs in 2020

- 85 hospitals reported patients visited in EDs
  - In addition, there are an estimated 24 free standing EDs (FSED)
  - Patients who visit FSEDs are not distinguished from patients that visit main campus hospital EDs
- Reasons for ED visits vary widely
  - Trauma from accidents, heart attacks, and acute events
  - Significant health issues resulting from chronic conditions
  - Patients presenting with symptoms of unknown causes

Federal law requires EDs to screen, stabilize, or transfer all patients

- EMTALA require hospitals with a dedicated ED to provide:
  - Emergency medical screening exam to determine if an emergency medical condition exists;
  - Stabilizing treatment for emergency conditions; and/or
  - Appropriate transfer to a hospital with specialized capabilities and the capacity to accept transfer of a stabilized patient

EMTALA = Emergency Medical Treatment and Labor Act
Source: 42 CFR 489.24 et. seq.

Major study questions

- Why do patients choose to use the ED if their diagnosis indicated they could have been treated in lower cost settings?
- How do age, payer, geography, and diagnosis impact ED utilization?
- What populations are FSEDs serving and how do they impact ED utilization?
- What strategies could ensure patients seek care in the most appropriate setting?

Research methods

- Data Analysis of VHI data
  - ED claims by payer, age, MH/SUD, acuity, geography
- Site visits to emergency departments
  - Hospital-based EDs and FSEDs
  - 15 sites across all regions of the state
- Literature review on reasons for ED utilization and strategies to ensure care in appropriate settings

Local Health Department Structure and Financing

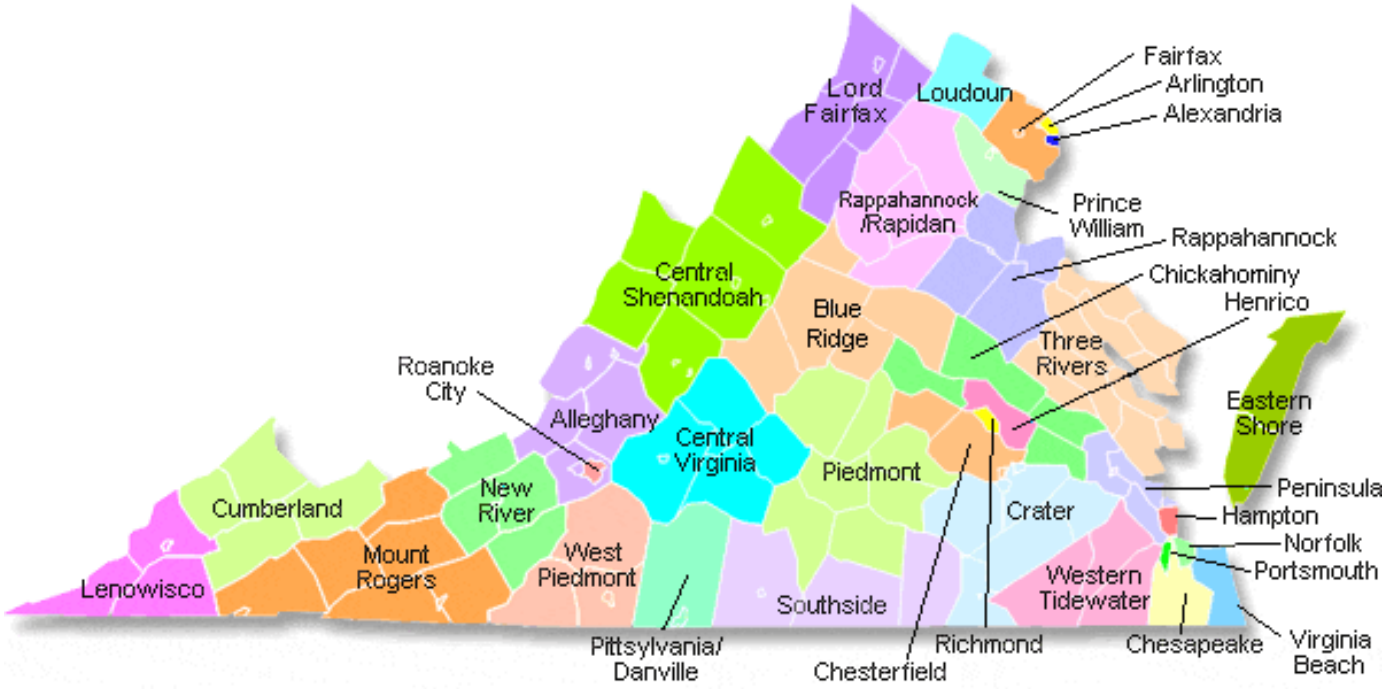
Analyst: Kyu Kang

Study purpose

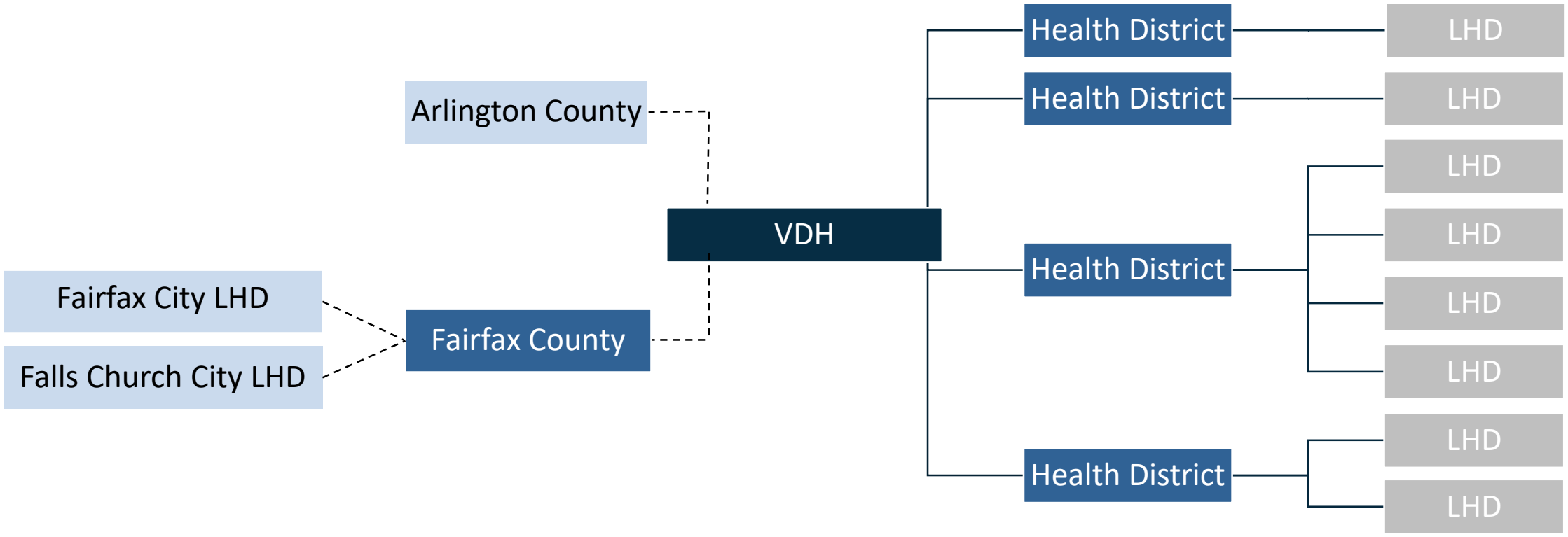
- Catalog and compare public health services provided by local health departments (LHDs)
- Assess whether LHD services are in line with recognized, public health standards
- Compare Virginia's LHD structure and financing to other states
- Recommend necessary changes

NOTE: Study mandate approved by the Commission on December 7, 2021.

There are 133 LHDs in Virginia, organized into 35 health districts



Virginia's local health department structure is mostly centralized



VDH = Virginia Department of Health LHD = Local Health Department

Every LHD provides a set of core services

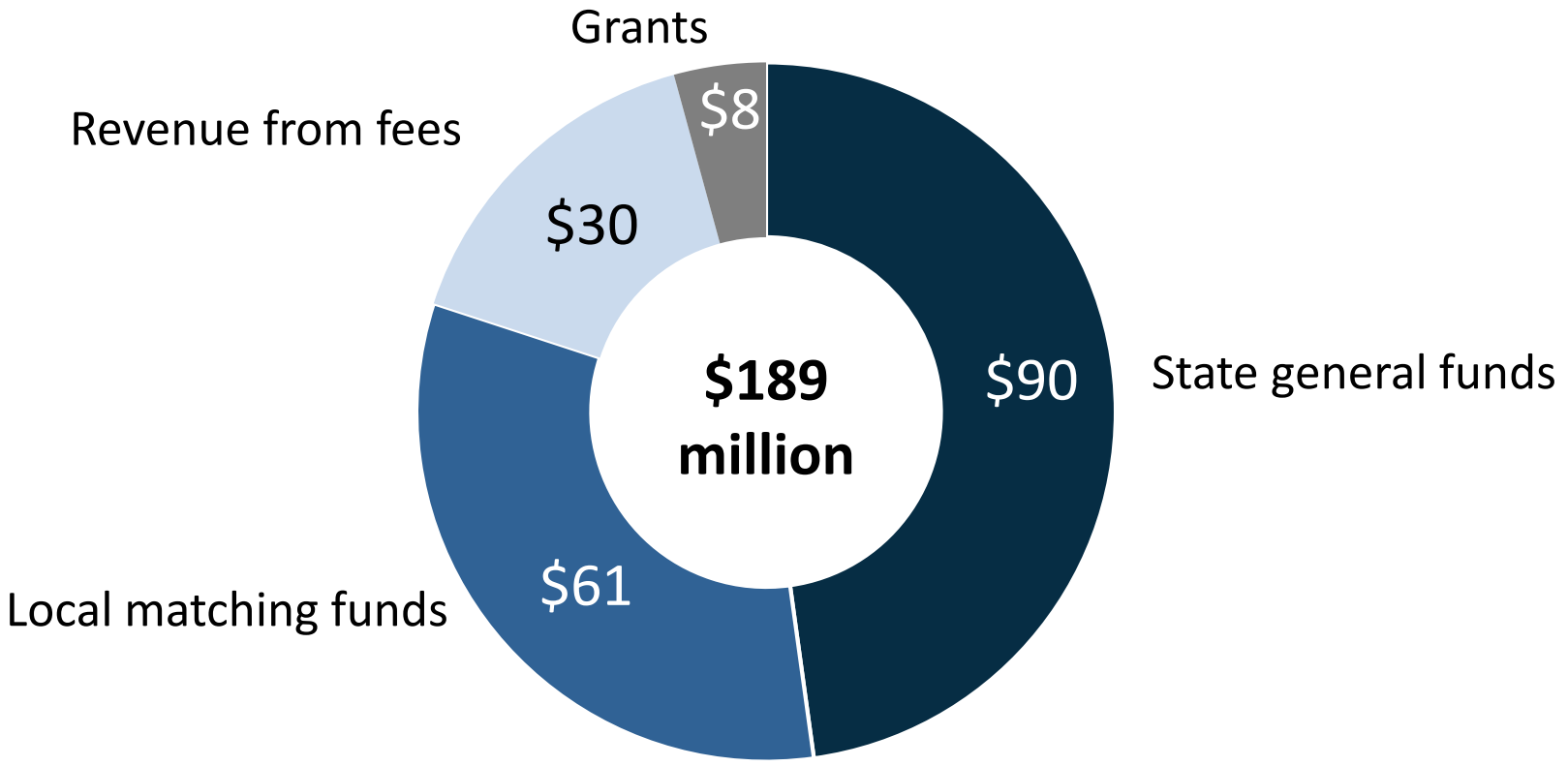
- Community Health (Community health improvement, clinic services, disease surveillance, etc.)
- Environmental Health (Establishment inspections, outbreak investigations, etc.)
- Other (LTSS screenings, emergency preparedness, vital records, etc.)

LHDs are funded through multiple sources

- Cooperative budget
  - State general funds (55-82% match)
  - Local government funds (18-45% match)
  - Revenue from services (e.g., insurance reimbursement, vital records fees, inspection fees)
- Grants (federal, state, local, private)

NOTE: The LHD cooperative budget requires a state/local match where the state takes on the majority of the cost.

In FY20, the total cooperative budget was $189 million



Major study questions

- **Programs & services** – How do services compare across Virginia?
- **Governance** – Is the organization of LHDs effectively supporting their work?
- **Staffing & capacity** – Is staffing commensurate with workload?
- **Financing** – Is funding commensurate with workload and need?

Research methods

- Data and document analysis
  - Local Government Agreements
  - DHRM staffing data
  - WebVISION encounter data
  - Vital records data
- Review of policies adopted by other states

Research methods (cont'd)

- LHD survey
  - Patient wait times
  - Staff travel time
  - Community partnerships
- Stakeholder interviews
- LHD site visits

Provider Data Sharing to Improve Quality of Care

Analyst: Jeff Lunardi

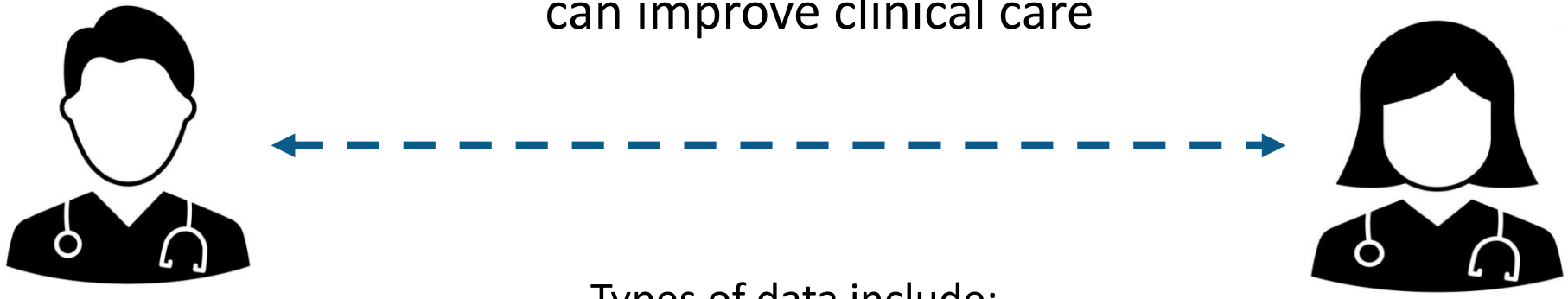
Study purpose

- Determine what data are most useful to providers to improve clinical care
- Assess barriers some providers face to participating in current data sharing programs
- Identify how data that are currently collected could be better used to improve clinical care and health outcomes

NOTE: Study mandate approved by the Commission on December 7, 2021.

Health data sharing has multiple potential uses

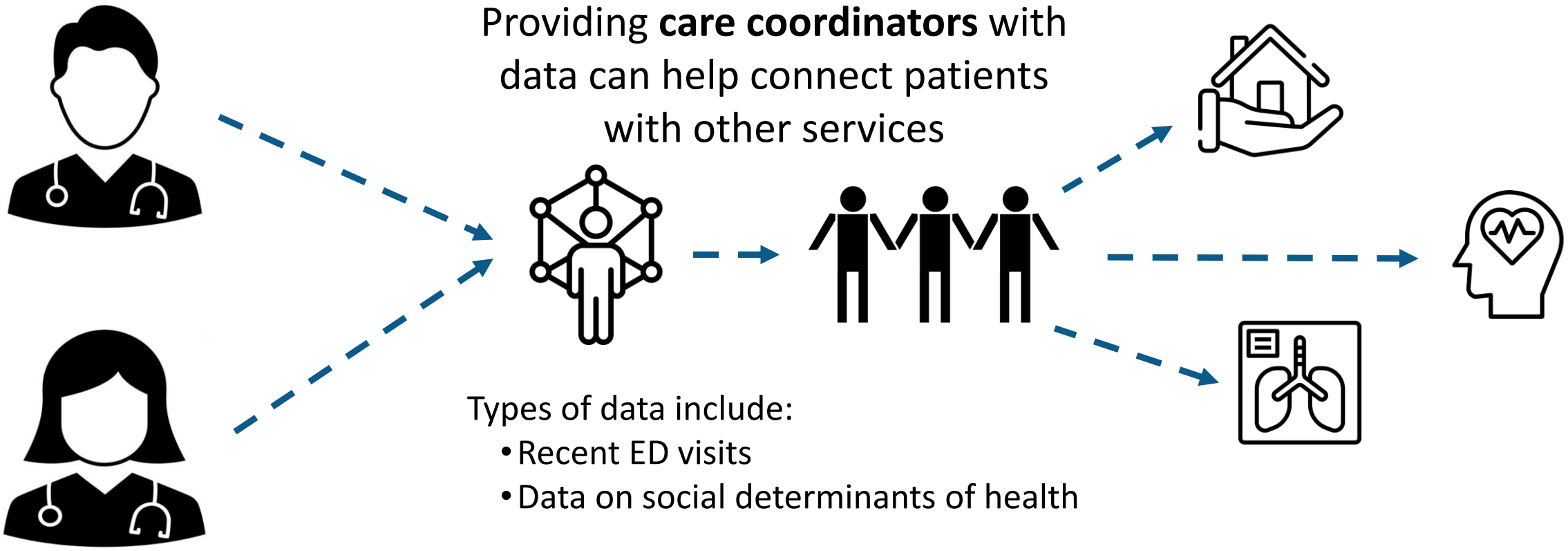
Provider-to-provider data sharing can improve clinical care



Types of data include:

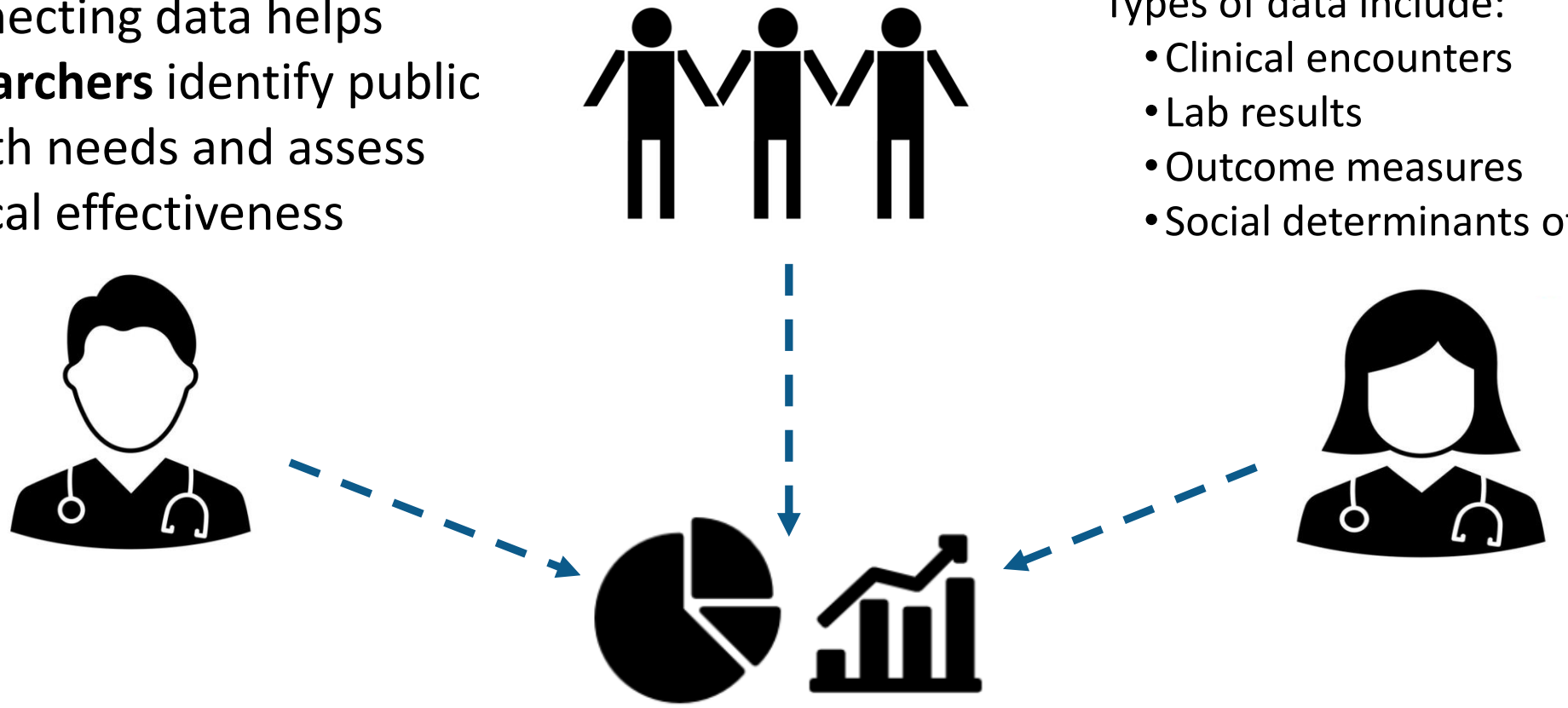
- Current prescriptions
- Lab results
- Recent ED visits

Health data sharing has multiple potential uses



Health data sharing has multiple potential uses

Connecting data helps **researchers** identify public health needs and assess clinical effectiveness



Types of data include:

- Clinical encounters
- Lab results
- Outcome measures
- Social determinants of health

Effective data sharing is complicated to achieve

- Stakeholder buy-in required to initiate data sharing
  - Clinicians
  - Health systems
  - Payers
  - Patients
- Seamless IT integration required to make data accessible and useful for users
- Patient consent and data security required to ensure privacy

Public and private health data sharing exists in Virginia to various degrees

- "Public" programs are operated by VHI and serve multiple purposes
  - Sharing data between hospitals and downstream providers
  - Facilitating access to national health information exchange
  - Reporting epidemiology data for research and surveillance
- Private data sharing exists between health systems and community providers but extent is not yet known

VHI = Virginia Health Information

VHI manages all current publicly supported health data sharing programs

Program name	Description	Goal	Type of data sharing
EXCHANGE	Share core set of patient data between providers through national system	Give providers some clinical history	Provider-to-provider
EDCC	Provide EDs, outpatient providers, and care coordinators real-time data on patient ED use	Provide EDs with clinical history; Provide care coordinators with alerts on ED use	Provider-to-provider Provider-to-care coordinator
Public Health Reporting Pathway	Collect patient immunization and disease data from providers	Provide data to VDH for research and surveillance	Public health research
Advance Care Directives Registry	Public repository of legal documents related to patients' medical decisions	Enable clinicians to know if a patient has a medical directive	Patient-to-provider

EDCC = Emergency Department Care Coordination

Major study questions

- What provider types and patients are currently using provider-to-provider data sharing programs?
- What challenges exist that may limit the effectiveness of current data sharing programs?
- What provider types and patients would most benefit from improved provider-to-provider data sharing?

Research methods

- Data analysis of users of existing programs
- Focus groups with providers
  - Users of current programs
  - Providers who may benefit from using existing programs
- Literature review for best practices in health data sharing
- Review of other state policies to foster improved health data sharing