

## **HEALTH CARE ADVISORY BOARD**

Meeting Summary  
September 8, 2014

### **MEMBERS PRESENT**

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

### **STAFF**

Sherryn Craig

### **GUESTS**

John Caussin, Jr., Fire and Rescue Department  
William Garrett, Fire and Rescue Department  
Maura Ardike, Fire and Rescue Department  
Michael Forehand, Inova Health System  
Sarah Broughton, Virginia Department of Medical Assistance Services (DMAS)  
Bob Eiffert, Health Department  
Shauna Severo, Health Department  
Rosalyn Foroobar, Health Department

### **Call to Order**

The meeting was called to order by Marlene Blum at 7:34 p.m.

### **June Meeting Summary**

The June 9, 2014 minutes were approved as submitted.

### **EMS Follow Up Discussion**

John Caussin, Jr, Assistant Fire Chief, Operations Bureau, Fire and Rescue Department; William Garrett, Deputy Chief, EMS Division, Fire and Rescue Department; and Maura Ardike, Operations Data Program Manager, Fire and Rescue Department returned to the HCAB to answer questions that were raised during the March budget meeting.

The EMS Transport Fee generated \$17 million in revenue in FY 2014, which goes to the County's General Fund. The revenue is not accessible to EMS, although the agency leverages the fee during its negotiations with the Department of Management and Budget (DMB). DMB restored \$1 million to the agency's budget to fund the ALS school. Twelve personnel are enrolled in the school to become ALS-certified providers.

Fairfax County has been awarded a Staffing for Adequate Fire and Emergency Response (SAFER) Grant. This three-year grant will allow the agency to provide one firefighter-medic on each ladder truck. Nineteen positions were created in 2013 and 12 positions in 2014. Grant funding will expire after 2015. The Board of Supervisors is committed to sustaining these positions beyond the grant period and will look to identify funding sources for FY 2016.

Given the region's traffic volume, the percent of the agency's ALS Transport Units on scene within nine minutes was 89 percent, but the agency's AED response rate within five minutes was 56 percent. Emergency vehicles in a response situation can save seconds using pre-empted traffic signals on the way to the scene. Depending on the acuity of the patient, vehicles may pre-empt signals during transport (i.e., hospital).

Of the County's 900 traffic signals, only 104 are enabled with preemption which allows the agency's vehicles to continue through a signal without stopping for oncoming traffic. Chief Caussin is working with the Department of Transportation to include pre-empted traffic signals in a comprehensive traffic plan. He will forward a 2006 report to Sherryn Craig that includes recommendations and strategies for implementing pre-empted traffic signals.

It costs \$2,000-\$3,000 to outfit each intersection with pre-empted traffic signals. About 90 percent of Prince William County's traffic signals are pre-empted and there is a separate funding stream used to finance/maintain these signals. Henrico County, which Chief Caussin felt was most comparable to Fairfax, has 90 percent of its signals pre-empted and uses a combination of County funds and proffers to finance its signals.

The sirens on the county's emergency vehicles can be manipulated using different pitches and sounds.

Response times are measured from the time a station is notified of an incident (e.g., tones sound) to on scene arrival. Responders have sixty seconds from when the tones sound to board the emergency vehicle. Using national standards, vehicles then have four minutes to arrive on scene. On scene arrival is determined by the location's address. However, the agency is now collecting data to measure how long it takes providers to reach the patient's side.

Over the past several years, the department has transitioned its BLS ambulances to ALS. This change has improved the agency's response times and decreased reliance on neighboring jurisdictions, like Arlington or Alexandria.

Based on national averages, attrition among paramedics occurs every 7-8 years. The goal of Fire and Rescue is to hire 48 ALS paramedics a year. Assigning a paramedic to every type of apparatus incentivizes paramedics to stay within the County. There is

greater flexibility to move around and gain experience on different vehicles and with different stations.

A firetruck and ambulance are dispatched together when responding to an emergency call. Paramedics are assigned to all transport units (i.e., firetrucks and ambulances) because the number of personnel required to stabilize a patient and/or carry him/her down a flight a stairs is six. A level one transport should have two paramedics to respond to a patient from arrival to transport.

With respect to the EMS Transport Fee, Fire and Rescue uses compassionate billing. Chief Caussin will follow up with the agency's recovery rate. An outside vendor is used to invoice and collect fees. The contract is open to competitive bid every five years.

With respect to the \$1 million cut in the agency's large apparatus replacement fund, Fire and Rescue has worked with DMB to leverage other grant funding to purchase the eight ambulances that it requires. Using these grant funds for vehicles means that other equipment and/or training may be deferred.

In preparing the FY 2016 budget, the County Executive has requested that all agencies plan for a 1 percent cut, which amounts to \$1.8 million. Budget projections for FY 2017 may become more problematic as all agencies have been asked to plan for a 3 percent cut, which is about \$5 million for Fire and Rescue.

EMS is using outcome-based performance measures to evaluate its effectiveness. Chief Garrett stated that improving STEMI outcomes (i.e., the percentage of patients arriving at the Emergency Department with a pulse) is one focus measure.

EMS has also seen an uptick in the administration of Narcan, suggesting an increase in drug overdoses, but what particular drug may be driving this trend is not known based on what data are collected and how. When paramedics arrive at a scene, a possible drug overdose may be suspected, but it is not confirmed until further tests are conducted at a hospital. EMS is working closely with its hospital counterparts to track this data. Given that some drugs are combinations of one or more illegal substances, it's also difficult to say what substance may have triggered the patient's reaction.

Chief Caussin welcomed the opportunity to return to the HCAB.

### **Commonwealth Coordinated Care (CCC)**

Sarah Broughton, Outreach and Education Coordinator, Office of Integrated Care and Behavioral Health, Virginia Department of Medical Assistance Services (DMAS), presented on a new demonstration project, Commonwealth Coordinated Care (CCC). The demonstration project represents a partnership between CMS Medicare and DMAS Medicaid. The project blends Medicare and Medicaid benefits for people who are receiving both types of care and will continue through December 2017. The intent of

CCC is to blend benefits into one health plan. Participants can choose one of three health plans. The three approved plans are Virginia Premier, Anthem Healthkeepers, and Humana. Humana is the only approved plan for the Northern Virginia region. A competitive selection process was used to identify the three health plans. An algorithm that considered the number of miles a patient needed to drive to access services and the number of specialists included in the plan directory factored into the selection process.

There are two ways to enroll in CCC. The automatic phase means participants are automatically enrolled in CCC and are notified in writing of the right to opt out within 60 days. Because Northern Virginia only has one plan, participants can voluntarily opt in. There is no open enrollment period, but rather rolling enrollment. Participants can switch between health plans at any time. Enrollment becomes effective the first of the month. However, if participants elect a new/different plan five days before the end of the month, they will not be enrolled the first of the next month, but need to wait for the following month to ensure they receive the proper forms and information for their respective plans.

Ms. Broughton will double check on whether patients who switch plans after satisfying their former plan's deductible will be required to pay again. However, there are no additional copays or premiums, with the exception of prescription drug plan copays. People who have a supplemental Medicare policy are not eligible for CCC.

There are no caps on enrollment. An estimated 78,000 Virginians are eligible for CCC. The program is voluntary, and based on national averages, about 30-35 percent of those eligible are expected to opt out.

DMAS is working to attract more providers, which is why automatic enrollment in Northern Virginia has been pushed back from October 1 to November 1. Health plans are required to reimburse providers at a rate no lower than Medicare's fee-for-service rates.

The intent of CCC is not to replace PACE programs. CCC is designed to provide care coordination to an expanded population. Medicare and Medicaid were not designed to work together seamlessly.

Ms. Broughton was not able to answer if other health plans competed to provide services in Northern Virginia, but were rejected. If that information is publicly available, she will provide it. Similarly, Ms. Broughton will follow up the plans' 5-star Medicare ratings.

Participants who are eligible for CCC must have full Medicare and full Medicaid, be 21 years of age or older, and live in one of three regions where the demonstration project

is available. The project just started, but participants tend to be 60 years and older, although there has been considerable interest among younger adults who are disabled.

Individuals who have an Elderly Disabled with Consumer Direction (EDCD) waiver are eligible for CCC. However, individuals with an Intellectually Disabled (ID) or Developmental Disability (DD) waiver are not eligible. Individuals with an Alzheimer's waiver or tech support are also not eligible as there are other opportunities for care coordination within those programs. CCC is available to individuals in nursing homes, but not to people using hospice or with comprehensive/supplemental insurance coverage.

CCC participants are assigned a care manager, who is typically a Registered Nurse (RN) or Medical Social Worker. The care manager conducts a health risk assessment. S/he reviews participants' transition data and what services they may have received or have not been able to obtain. Assessments are conducted in person, unless the individual is determined to be "community well," and then assessments may be made telephonically. Assessments must be completed within a specified time frame and they are used to inform the participants' Interdisciplinary Care Team (ICT). Participants can have any provider(s) they choose on their ICT.

Ms. Broughton will follow up on whether CCC reimbursement is risk-adjusted annually, or more frequently (e.g., quarterly). In order for providers to receive full capitation, certain quality measures must be met.

Personal interest stories are also available to demonstrate the project's successes/outcomes.

As of September 1, 20,824 individuals are enrolled in CCC. There are 3,266 that have opted in. Ten thousand will be automatically enrolled in the Charlottesville and Roanoke regions. Automatic enrollment in Northern Virginia begins November 1. Ms. Broughton did not have exact figures on the number of opt outs but estimated it at several thousand. As CCC continues to enroll participants, more opt outs are expected. DMAS is tracking reasons for participants un-enrolling in CCC. Ms. Broughton will review the guidelines around assisted living, but generally, the cost of housing would not be covered by CCC.

Of particular note, the three-day hospitalization requirement before a patient is eligible to receive services in a skilled nursing facility (SNF) is waived under CCC.

Ms. Broughton stated that an algorithm was used during the plan selection process to ensure network adequacy among primary and specialty care providers.

Individuals who are incarcerated would not be eligible for CCC, but if they were released and eligible for Medicare and Medicaid, they could enroll in the project.

## **HCAB Workplan**

Brenda Gardiner will present on the implementation of HMA's recommendations to integrate safety net services at the HCAB's October meeting. Ms. Craig will follow up with her to determine if Patricia Harrison wants to come to the HCAB's November meeting. The Health Department's presentation on the Nurse Family Partnership (NFP) will be moved from October to November. Ms. Craig will work with HD staff to schedule a presentation on immunizations in December and a briefing on actual and projected demand for aging services for April or May. The Health Department has also received notification that Special Exception applications have been filed and accepted for two Sunrise Assisted Living Facilities, one in the Springfield district and the other in Dranesville. Ms. Craig will conduct further research of the Reach Out and Read program.

There being no further business, the meeting adjourned at 9:40 pm