

## **HEALTH CARE ADVISORY BOARD**

Meeting Summary

October 16, 2013

### **MEMBERS PRESENT**

Marlene Blum, Chairman  
Rose Chu, Vice Chairman  
Bill Finerfrock, Vice Chairman  
Dr. Michael Trahos, DO  
Ann Zuvekas  
Ellyn Crawford  
Judith Beattie  
Francine Jupiter

### **STAFF**

Sherryn Craig

### **GUESTS**

Leslie Johnson, Department of Planning and Zoning  
Lorrie Kirst, Department of Planning and Zoning  
Michael Forehand, Inova Health System  
Rosalyn Foroobar, Health Department  
Sharon Arndt, Community Transformation Grant, Department of Community and Neighborhood Services  
Glen Barbour, Health Department

### **Call to Order**

The meeting was called to order by Marlene Blum at 7:38 p.m.

### **September Meeting Summary**

The minutes from the September 9 meeting were accepted as submitted.

### **Discussion of Medical Care Facilities**

Leslie Johnson, Zoning Administrator, Department of Planning and Zoning (DPZ), announced that the Board of Supervisors (BOS) approved the Temporary Healthcare Structures Zoning Ordinance Amendment as originally submitted to the BOS on June 4, 2013. To date, the County has approved one temporary health care structure. In light of the pending closure of the Northern Virginia Training Center (NVTC) closure, DPZ will continue to monitor this issue.

A medical care facility, once it has been determined, is a Category 3, Special Exception Use: an application is filed, a fee is assessed, HCAB and Planning Commission review is required before the BOS ultimately approves or denies the application. Lorrie Kirst, Senior Zoning Administrator, DPZ, prepared a historical timeline regarding the definition of medical care facilities in the County's Zoning Ordinance, which was adopted in August 1978. The first revision to medical care facilities was made in 1979, deleting

freestanding nursing facilities with a capacity of 50 or more beds in Residential Districts (R-E through R-8) pending special exception approval. Changes made in 1982 removed health maintenance organizations (HMOs) from the medical care facility definition in addition to excluding medical laboratories from consideration. The districts where medical care facilities could be built also expanded to include commercial and industrial areas (C-5, C-6, C-7, C-8, I-5, I-6).

Bill Finerfrock asked what the rationale was for deleting HMOs.

Ms. Johnson maintained that the definition of medical care facilities, by design, is broad. In 2006-2007, DPZ made an office use determination for the Lorton HealthPlex, despite the project having an ambulance bay included in its proposal. The former Zoning Administrator, Eileen McLane, met with the HCAB and reached out to Emergency Medical Services (EMS) staff to revise the agency's interpretation of medical care facilities, which now include any entity that provides 24 hour care with permanent beds, has licensed physicians and/or licensed medical personnel, and receives and treats EMS transported patients with life threatening injuries or illness. Applications that do not meet those criteria are considered most similar to a physician's office or clinic providing services on a walk-in basis and are zoned by right, rather than special exception, depending on the particular district.

Sentara has now entered the Northern Virginia market, taking over 7,000 square feet on the first floor of one of the office buildings located in the Lorton Town Center. While the facility will provide urgent care and is open 24-hours/7 days a week, it will not accept EMS transported patients. Therefore, Sentara's application is considered a medical office building, and is not subject to the special exception process within the Zoning Ordinance.

The DPZ is now aware of the Certificate of Need Process (CON), which is key in making a medical facility determination. Ms. Johnson said that in the future, DPZ staff will ask all applicants whether a CON is required or has been approved.

DPZ staff is also reaching out to Health Department staff regarding applications that may require a medical care facility determination. As an example, DPZ discussed Inova's proposal to build a psychiatric assessment center off of Williams Drive in Fairfax. The center will have a 24-hour telephone hotline, and while it's possible that a patient in crisis may need to be transported to the hospital, the center would not accept EMS patients. Therefore, the DPZ has issued an office use determination for the project.

Lorrie Kirst cited a recently received application from an Adult Day Health Care (ADHC) provider, which DPZ has not yet sent to the HCAB for review. The County has not defined a specific use for ADHCs in the Zoning Ordinance. Historically, DPZ has treated

ADHCs as child daycare centers, which are permitted by right in commercial districts and by special exception in residential districts.

When asked about the type of ADHC services the proposed applicant will provide, Ms. Kirst answered that the primary population is people with Alzheimer's and dementia.

Ms. Johnson acknowledged the HCAB's concerns, but felt the HCAB and the DPZ may need to agree to disagree. Adding a specific use for ADHCs within the Zoning Ordinance, in her view, was unnecessary. Given the absence of 24-hour residential care, Ms. Johnson maintained that ADHCs were most similar to a childcare center/daycare facility. Ms. Kirst will send the applicant's request to the HCAB, but after initial review and discussion, DPZ is inclined to classify it based on what it is most similar to – a child daycare center.

HCAB members pointed out that while there are some exceptions for children with medical needs, daycare centers, for the most part, provide the same level of care for each child. This same model does not apply to Alzheimer's patients. As patients progress through different stages of the disease, they require different and more advanced levels of care, especially with respect to medications and medication administration. ADHCs, including those specialized for people diagnosed with Alzheimer's and dementia, require a registered nurse or licensed staff to dispense medication.

The HCAB asked how the proposed ADHC facility is funded and whether they receive reimbursement from Medicaid (which occurs only among patients who are approved for a waiver that, in its absence, would make them eligible for nursing home and assisted living care). This patient population has serious, life-threatening co-morbidities. Rosalyn Foroobar will provide the criteria that are used in determining an ADHC client's Medicaid eligibility to receive community-based services instead of skilled nursing care.

Ann Zuvekas suggested that on applications where there may be doubt as to what does and does not constitute a medical care facility, that DPZ err on the side of caution and call the Health Department and the HCAB. Ms. Johnson said that communication between DPZ and the Health Department has improved. However, given that ADHCs do not have permanent beds, it seems appropriate to treat them like child daycare centers.

Ms. Blum pointed out that the only difference between ADHCs and assisted living facilities (ALFs), the latter of which is a medical care facility, is overnight stays. The needs of the participants, the levels of care, and the types of expertise are the same for ALFs and ADHCs.

Moreover, Ms. Blum noted that the definition of medical facilities makes no mention of 24-hour, residential care. Rather, it is DPZ's interpretation that limits its use, not the definition itself.

Ms. Johnson explained that the special exception process carries with it significant policy implications. It's not easy for applicants to go through, and it's expensive. Changes to the Zoning Ordinance, including the creation of a separate use for ADHCs, cannot be taken lightly. Decisions made during the evaluation process are central to land use.

Ms. Johnson also observed that ADHCs are licensed by the state, questioning the need for an additional layer of review. Ms. Blum reminded Ms. Johnson that the state also regulates ALFs and nursing homes. Mr. Finerfrock objected to Ms. Johnson's conclusion, arguing that while the Special Exceptions process may appear seemingly redundant, it exists to ensure there is a public means for assessing community needs, accessibility, affordability, and quality for new and expanded health care services. The County's Special Exception process creates a local mechanism for certifying that facilities are safe in addition to delivering a standard of care commensurate with the community's standards.

The HCAB cited the Agape Adult Day Health Care Center as an example where there were concerns about medication administration, staffing, training, and reimbursement.

The HCAB also questioned the office use determination of the Kaiser Permanente Tyson's Corner Medical Center, a facility that houses an Observation Unit (i.e., overnight beds) and an Infusion Center. Ms. Johnson said she had reviewed the determination memo and while there were observation beds, Kaiser did not provide 24-hour care, nor did they have any ambulance bays. The HCAB felt that regardless of whether Kaiser accepts EMS transports, the facility received several CONs, suggesting that it should have been classified a medical care facility, rather than an office use.

Ms. Johnson concluded her presentation by reiterating DPZ's historical treatment of ADHCs as child daycare centers. While childcare may not be the best comparison, Ms. Johnson felt ADHC services were no different than those provided at Senior Centers.

The HCAB disagreed and noted the difference between an ADHC client's acuity/functional/cognitive abilities and that of someone who attends a Senior Center. Moreover, not all ADHCs are created equal. As the population ages and greater demand for community based services arise, the HCAB anticipates more applications from private ADHC providers, as well as greater specialization for those diagnosed with Alzheimer's and dementia. Given how DPZ applies the medical care facilities definition, the HCAB is concerned that the County will not be able to respond to changes/innovations in how health care and health care services are delivered.

The HCAB agreed to send a memo to the BOS that does not make a recommendation but outlines the discussion that occurred with DPZ staff.

### **Community Health Improvement Plan (CHIP)**

Sharon Arndt, Project Director, Community Transformation Grant, briefed the HCAB on the Partnership for a Healthier Fairfax's Community Health Improvement Plan (CHIP). The complete CHIP plus a shorter version will be available on the Partnership's website. Limited copies of the longer CHIP are available.

Ms. Arndt outlined the CHIP's development phases. The assessment phase began in November 2008 with the Local Public Health Systems Assessment (LPHSA). It continued with four additional Mobilizing for Action through Planning and Partnership (MAPP) assessments and a Policy, System, and Environmental (PSE) Scan. Several HCAB members were involved in the assessment phase, which concluded January 2013.

The Partnership divided into Strategic Issue Teams. Section criteria were developed to prioritize health improvement opportunities that were identified during the assessment phase.

The Plan Development Phase involved several steps culminating in the final product, which is the CHIP:

- Identifying strategic directions
- Clarifying goals
- Developing strategies/objectives
- Identifying activities
- Obtaining community input
- Preparing the CTG grant proposal
- Developing a CHIP

The CHIP includes seven priority issues to address 30 CHIP objectives (15 of the 30 have been included in the County's Community Transformation Grant (CTG) and 7 of 30 have limited grant funding as piloted CTG objectives).

The first Priority Issue – **Healthy and Safe Physical Environments** – includes the development and implementation of policies that promote healthy and safe physical environments for all who live, work, and play in the Fairfax community.

The second Priority Issue – **Active Living** – has three identified goals:

- Increase the number of children and adolescents who engage in daily physical activity.
- Increase the number of adults who engage in daily physical activity.
- Promote the sustainability of programs and facilities that promote physical activity.

The third Priority Issue – **Healthy Eating** – has two identified goals:

- Increase the accessibility and affordability of healthy foods.
- Increase the number of environments that promote healthy food choices and educational resources.

The fourth Priority Issue – **Tobacco-Free Living** – includes reducing tobacco use and exposure to secondhand smoke and associated unhealthy air contaminants in outdoor recreational environments and multiunit housing environments.

The fifth Priority Issue – **Health Workforce** – includes having a health care workforce that is responsive to the health care needs of a diverse population.

The sixth Priority Issue – **Access to Health Services** – includes two identified goals:

- Improving access to primary and specialty care, including oral and behavioral care.
- Improving access to services that promote social and emotional wellness, prevent suicide, and decrease the stigma associated with mental illness and substance abuse.

The seventh Priority Issue – **Data** – includes developing recommendations for a comprehensive public health data collection, monitoring, analysis, and reporting system to support evaluation of health outcomes.

Access to community level data remains a priority. The Partnership had challenges accessing subpopulation data. Drilling down to the community level is difficult, and for some datasets, not yet possible.

Mr. Finerfrock said that CMS has released a lot of County level Medicare data, which can be cross-tabulated by disease and race/ethnicity.

Ms. Zuvekas replied that subpopulation data has value, but to target interventions, there must be access to sub-community data (i.e., high need areas). She recommended hospital discharge data, which could be de-identified, but still provide information on health conditions, health outcomes, and insurance type by zip code.

Ms. Arndt said that one of the advantages to having a CHIP is that it has positioned the Partnership to apply for grants to implement the objectives.

Ms. Blum encouraged HCAB members to review the objectives and key actions of the CHIP and consider getting involved in a specific issue. For people who are interested in working on an individual topic, committing financial or other resources, they should contact Sharon Arndt at [livehealthy@fairfaxcounty.gov](mailto:livehealthy@fairfaxcounty.gov).

## **Health Insurance Marketplace Customer Service Reference Guide for Fairfax County Employees**

Glen Barbour, Public Information Officer (PIO), Health Department, provided an overview of online materials designed to help Fairfax County employees respond to customer service requests on the Health Insurance Marketplace. Fairfax County has no role in enrolling the general public into the Health Insurance Marketplace, but it has a responsibility to know how to direct the people it serves to the resources they need to learn about and enroll in health insurance plans.

An overview of the marketplace has been prepared for employees and includes the following information:

- The Health Insurance Marketplace opened October 1. Individuals and families (and small businesses) can purchase health insurance through the Virginia Health Insurance Marketplace.
- Open enrollment will last from October 1, 2013 through March 31, 2014. Coverage begins January 1 at the earliest.
- In order to have coverage by January 1, 2014, individuals, families and small businesses must purchase insurance by December 15, 2013.
- You cannot enroll in a Medicare plan through the exchange.
- There will be a number of plans to choose from; people can select a plan that best fits their budget and their needs. Plans are categorized as "bronze," "silver," "gold," and "platinum."
- All plans will cover a number of essential services, such as maternity care, hospitalizations, and prescription drugs. Many preventive services will be provided for no out of pocket cost.
- Insurers cannot deny anyone coverage or charge them more because of pre-existing conditions or if you get sick.
- Help to lower the cost of insurance will be available to people who are lawfully present making between 100% and 400% of the Federal Poverty Level.

There are two ways to refer people to the Marketplace. Websites and phone numbers have been provided to employees. For consumers who are ready to learn about and/or buy health insurance through the Marketplace, employees are directing them to [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596. For consumers who require a high level of support and/or in-person assistance in learning about or buying insurance through the Marketplace, employees are directing them to [www.enroll-virginia.com](http://www.enroll-virginia.com) or 1-888-392-5132/703-647-4748.

A suggestion was made for the County to distribute materials clarifying the restriction on Medicare plan enrollment through the exchange. It was felt that this provision of the law had not been communicated well to people. Mr. Barbour said that the County had not planned to create its own content/messaging and cited resources that are

currently available. However, he said that he would relay the HCAB's concerns to the County's communications team.

Mr. Finerfrock observed that despite having the availability to buy health insurance through an exchange, for all practical purposes, people may still find themselves uninsured. The plans that are available to purchase are still ones with high deductibles. An honest discussion needs to be had regarding what people are buying in order to be considered "insured."

Dr. Michael Trahos, DO, informed the HCAB of the 90-day grace period for people to pay their health insurance premiums. Insurers are only required to guarantee physicians payment for the first 30 days of the grace period. Thereafter, the risk falls entirely to the provider. Physicians may provide care to a patient over the 90 day period only to receive payment for one month of services. Dr. Trahos, DO said that many of his colleagues will refuse to accept this pool of patients in order to protect their practices.

### **Update on Community Health Care Network (CHCN) Specialty Care**

Rose Chu, Chairman of the CHCN Community Advisory Committee (CAC) provided a report on access to specialty health care. A presentation on Project Access of Northern Virginia (PANV) was scheduled for the CAC, but Dr. Eapen was forced to cancel at the last minute. Started in 2007, PANV is a 509(a)3 nonprofit entity under the auspices of the Medical Society of Northern Virginia Foundation (MSNVAF). The mission of PANV is to provide access to no/low cost specialty healthcare to the high risk, uninsured, low-income in the Northern Virginia area who receive their primary care at area safety nets.

However, because of the intrinsic difficulties involved with volunteer specialty physician recruitment and the overwhelming need for specialty care, PANV has had problems successfully fulfilling its mission and in 2012, the MSNVAF had exhausted its resources (staffing, time, monies, etc.). Because a minority of MSNVAF board members still felt that PANV was a worthwhile mission to pursue, the project was placed under new *pro bono* management (i.e., Dr. Eapen) in February 2013, and its processes and procedures were revamped to accommodate the limited resources available to meet its mission.

While Dr. Eapen was not present at the CAC meeting, the group did receive an outline of her presentation in advance and expressed concern over the challenges that Dr. Eapen identified. Dr. Eapen reported that formerly independent practices (individual and group) now bought by Inova are no longer allowed to provide *pro bono care*. The CHCN staff has also reported similar experiences when making requests to physicians who once provided specialty care to safety net clients. Furthermore, the University of Virginia (UVA) is beginning to pull back on the number of specialty care referrals it will accommodate.

HCAB members acknowledged that even before the budget cuts to CHCN or Inova purchasing private practices, safety net clients' access to free specialty care had always been problematic; demand exceeds supply. For example, long waiting lists have been in place for CHCN patients requiring physical therapy services. However, if what Dr. Eapen and CHCN are reporting is true, than an already serious situation has become even more precarious.

Moreover, Inova is still billing copays to CHCN patients that have been seen at its hospitals.

The HCAB expressed interest in learning more about PANV and Inova's policies governing its practices' participation in providing *pro bono* specialty care. Health Department staff will reach out to Dr. Eapen, Inova, and other safety net providers and ask them to attend the November HCAB meeting on Wednesday, November 13. The HCAB is also scheduled for an update from the Health Department on the cuts that were made to CHCN's specialty care in the FY 2014 budget.

### **Update on Fairfax County 50+ Safe & Healthy Community Subcommittee**

Judith Beattie, the HCAB representative to the subcommittee, provided a brief update on the group's progress to date. The Subcommittee is required to complete its report by January. Community meetings were organized throughout the summer and fall, providing a significant amount of information.

The supply of geriatric care services is not adequate to meet the projected demand. A shortage of caregivers and nurses will only contribute to the supply issues.

Trends are showing that more people are interested in community-based, rather than institutionalized care. Aging in place, staying in the community are what people want.

Several actions were identified to promote healthy, active lifestyles among older adults:

- "Senior playgrounds"
- Forming partnerships with fitness centers to provide discounted memberships to seniors
- Providing personal trainers and exercise programs to seniors

The subcommittee is also exploring ways to engage other community-based organizations and recruit more volunteers.

### **Other Business**

*Northern Virginia Health Foundation's Summary of Northern Virginia Health Summit.* A summary report of the Northern Virginia Health Summit was provided in the October meeting packet. Inova has also posted its Community Health Assessment reports online.

There being no further business, the meeting adjourned at 9:49 pm.