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VIRGINIA STATE BOARD OF HEALTH
WORK MEETING MINUTES
THURSDAY, JULY 25, 2002

Call to Order/Approval of Minutes:

Dr. Charles Hickey, Chairman, called the meeting to order at 10:00 a.m. at the Fair Oaks Holiday Inn in Fairfax, Virginia.

Members Present: Charles W. Hickey, DVM, Chairman; Daniel L. Williams, Jr., Cora L. Gray, RN, MSN, Executive Committee; Julie Leftwich Beales, MD, PhD; Sally J. Duran, Vice-Chairman, Executive Committee; Jack O. Lanier, Ph.D., Shelia W. Elliott, PharmD; Hunter M. Gaunt, Jr., M.D.

Members Absent: Douglas L. Johnson, Ph.D.; James R. Schroeder, D.D.S.; Katherine "Kandy" Elliott; Shirley Kelley, R.N,

Staff Present: Robert Stroube, Commissioner; Helen Tarantino, Deputy Commissioner for Administration; Jeffrey L. Lake, Associate Commissioner for Community Health Services; Joseph Hilbert, Executive Advisor to the Commissioner; Rene S. Cabral-Daniels, J.D., M.P.H.; Staff to the State Board of Health.

Dr. Hickey began the meeting at 10:00a.m.

Mrs. Cabral-Daniels reviewed the contents of the meeting packets and logistics for the day.

Minutes of the April 2002 meeting were reviewed with Dr. Hickey noting that the minutes should not reflect him as having seconded the motion to accept the minutes from the February meeting.

A motion to pass the minutes with the amendment was made and it was properly seconded and carried unanimously.

Update of Gift to Paul Matthias

Dr. Hickey asked Mrs. Cabral-Daniels to arrange for Paul Matthias to attend the October meeting so that the Board could present him with a resolution. Dr. Hickey informed new members that Paul served as former staff to the Board for a number of years and did an outstanding job while in that role. Rene asked that Board members interested in contributing toward the gift for Paul see her after the meeting.

Review of Packet Materials from May and July Meetings

Dr. Hickey reviewed the documents listed in the agenda and asked whether anyone had any comments about them. There were no comments.

Nursing Facility and Hospital Licensing Fees

Nancy Hofheimer stated that nursing facility and hospital licensing fees were set in 1979. The majority of the money available to perform surveys comes from general funds. The proposal concerning nursing facility and hospital licensing fees arises from a desire to turn the cost of surveys over to those who most benefit from them- the providers. The Center for Quality Health Care Services and Consumer Protection (CQHCS&CP) licensed 253 hospitals and 190 nursing homes. The cost to those providers is approximately several thousand dollars each.

Dr. Hickey added that if the fees were covered as is being proposed in the legislative amendment, the program would pay for itself. While the costs to perform licensure surveys have increased since 1979, the fees collected have not. In addition, an annual fee increase would be easy to administer.

Mrs. Hofheimer concurred with Dr. Hickey and noted that there is precedent for the proposal. The Department of Health Professions charges fees for its services based on cost. Within the Virginia Department of Health the Division of Water Supply Engineering administers its programs based upon cost.

Mrs. Duran asked whether CQHCS&CP received federal funds. Mrs. Hofheimer replied that sixty percent of the funds were federal funds. The federal government pays seventy-five percent of FTE salary and requires a state match of twenty-five percent. This financing process is often difficult to administer because the federal fiscal year differs from that of the state. Therefore, there is often a delay in receiving the complete funding. In addition, the state licensure regulations represent minimum but effective safety requirements. The federal regulations are more stringent than those of the state. Mrs. Hofheimer noted that Virginia Department of Health (VDH) senior management has always been supportive of the proposal but that the past two administrations were reluctant to raise fees, as it might be perceived as a tax increase.

Dr. Hickey asked whether Mrs. Hofheimer could suggest statutory language that would tie the fee amount to a cost-benefit analysis that was updated every two years. Mrs. Hofheimer agreed but noted that all regulations have to be reviewed every four years. Mrs. Tarantino reminded the Board that the proposed language is to have the Board set a fee. As an alternative, the CQHCS&CP will put forth a suggestion in the VDH legislative package to ask the legislature to do so.

Mrs. Duran asked Mrs. Hofheimer if she felt the federal funds were sufficient. Mrs. Hofheimer responded that the federal Office of the Inspector General was reviewing the federal funding process. There is a wide variation. The state is responsible for twenty-two percent of the funds while the federal government's responsibility is for seventy-eight percent. The responsibilities inherent to the program will likely increase with greater oversight of medicine.

Mrs. Duran announced that she was concerned about “federal mandate creep” coming down to the states. She described that phenomenon as an increase in state responsibilities without a corresponding increase in funds. She noted that the gap would have to be absorbed by general funds. She would like the Board to send a message to the federal government that the gap should remain the federal government’s responsibility and not that of the state.

Dr. Lanier asked how these surveys related to the Joint Commission on the Accreditation of Health Care (JCAHO) surveys. Mrs. Hofheimer responded that the Centers for Medicare and Medicaid Services (CMS) has promulgated regulations that state JCAHO accredited hospitals are deemed to be compliant for Medicare and Medicaid certification. All hospitals in Virginia are accredited by JCAHO. VDH performs validation surveys on fifteen percent of the hospitals. In addition, all Medicare complaints are investigated by CQHCS&CP.

Request for Applications

Nancy Hofheimer informed the Board that SB490 of the 2002 session of the General Assembly mandated the Commissioner to re-issue a Request for Applications (RFA) for nursing home beds in specified planning districts. The bill that was signed into law mandates 60 beds to be available in Planning District 11 (PD 11) and 120 beds to likewise be available in Planning District 13 (PD13). The bill was partially motivated by the bankruptcy of a nursing home corporation that was given a Certificate of Public Need for extra beds. The corporation was then unable to build the approved beds. In the past three years there has been 90% occupancy in PD11 of existing nursing home beds. Thus, PD 11 did not meet the threshold for RFA issuance. However, members of the General Assembly wanted the beds to be added to PD11. Therefore, the increase in beds for PD11 is facility-specific. The RFA for PD 13 is competitive.

COPN staff believes there is a need for additional nursing home beds in Bedford. Yet the State Medical Facilities Plan (SMFP) does not allow VDH to consider institution-specific need. The SMFP is in the process of being updated and this issue is being discussed by the SMFP Advisory Committee.

The SMFP Advisory Committee is also considering lowering the occupancy threshold for needing new beds from ninety-five to ninety-three percent. There is a decrease in nursing home occupancy statewide. This decrease is likely due to the increase in popularity of assisted living facilities.

Mrs. Duran suggested the SMFP Advisory Committee consider urban versus rural considerations in nursing home occupancy. Mrs. Hofheimer agreed and noted that other factors were being considered such as quality. Mrs. Hofheimer then stated to the Board that she was asking for its approval to publish the Request for Applications.

Conditioning of COPN

Mrs. Hofheimer provided a handout for this part of her presentation. Conditions on COPNs require applicants to provide charity care to indigent patients or to facilitate the development and operation of primary medical care services. The Commissioner may condition the approval of a certificate (i) upon the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care or (ii) upon the agreement of the applicant to facilitate the development and operation of primary care services in designated medically underserved areas of the applicant's service area. Hospitals and nursing facilities must attest in their licensure application that they have complied with COPN conditioning agreements. In 2000 sixty-four facilities failed to meet their agreed-upon conditions and were each required to file a plan of correction. In 2001 the number of facilities required to file a plan of correction was five.

Initially, COPN conditions were required of applicants who were providing charity care below the median level provided by facilities within the applicant's health planning region (HPR). The conditions required these applicants to provide the requested new services free as charity care to indigent patients at least at the HPR median level. However, the median level of charity care provision in an HPR is generally relatively low as compared to the average. This is particularly true in HPRs with state teaching hospitals.

The VDH has a number of evolving policies that it believes will improve the COPN process. It will use the average level of charity care provision in an effort to be fair to those planning regions with state teaching hospitals. To correct the inflationary effect of state teaching hospitals on their averages, the average will be calculated from charity care dollars at 100% of the federal poverty level net of payments to and receipts from the indigent care trust fund. In addition, the option of facilitating the development and operation of primary medical care services to medically underserved persons in the applicant's planning district was added as an alternative method of meeting the percentage required.

Therefore, applicants are required to provide services at a reduced rate or free of charge within the applicable service area or planning region. If the applicants attempt to do so but are unsuccessful, the applicant may provide direct financial support to a community-based health care service. The values must be equal to or greater than the difference between the terms of the condition and the amount of direct care provided. It is also not a substitute for other charitable giving as determined by the applicant.

Mrs. Elliott asked how members of the public were to find out about the charity care. She knows of people in need of such care that state they are unable to find it. Mrs. Hofheimer stated that the public could call the health department, the Free Clinics, etc. She will bring up this issue with the SMFP Advisory Committee.

Mrs. Duran asked whether CQHCS&CP had considered simplifying the COPN application. Mrs. Hofheimer agreed to consider application simplification.

Dr. Lanier commended Mr. Hilbert on the outstanding job he has done in preparing the mandate material. He found it to be very helpful and particularly appreciated the explanations. He suggested Mr. Hilbert provide an oral explanation of unfunded mandates versus public need and necessities versus niceties.

Mr. Hilbert began by explaining that there was actually a hierarchy of mandates. For example, some legislation is conditioned upon whether funds are available. There are few mandates, if any, that VDH is not responding to at all. This fact needs to be considered in light of what the public would like us to do with regard to the mandate. The VDH response to a mandate is often dependent upon the amount of funds it has available to fulfill it. This response is not the same as saying a mandate is unfunded.

Mrs. Tarantino added to the presentation by reminding the Board that VDH does not have entitlement programs. Other agencies such as the Department of Social Services receive what is termed "sum-sufficient" appropriation.

Mrs. Duran asked whether VDH has reviewed mandates that are obsolete. In other words, are the demands on VDH appropriate?

Dr. Stroube explained that indeed the agency has reviewed what it believes to be obsolete mandates. For example, at one time it tried to transfer its responsibilities concerning bedding, as it believed those responsibilities could be better handled by another agency such as those concerned with consumer protection. However, others, such as furniture manufacturers, believed this responsibility should continue so that they wouldn't have to be licensed by other states. Dr. Stroube pointed out that VDH was successful in its attempt to reduce its statutory responsibilities concerning mosquito control. However, he concluded, there are a few responsibilities that VDH has tried to transfer. Generally, the lack of appropriations serves as the impetus for such transfers.

Dr. Stroube noted that VDH has also been pro-active in preventing additional mandates that are unfunded. When confronted with proposed legislation, it advocates additional language that generally reads, "from such funds as may be appropriated" be added to the bill. For example, VDH is trying to decrease its responsibilities concerning the Comprehensive Services Act because it requires substantial staff time.

Cancer Registry

Dr. Diane Woolard provided the Board with an update of the cancer registry and its ability to respond to the notification requirement. She provided a handout to Board members. The cancer registry was created in 1970. Reporting was voluntary until 1989 when mandatory reporting was required to enable VDH to generate accurate statistics. The registry requires identifying information because patients often see more than one provider, each of whom has to report. In addition, patients may develop more than one cancer, each of which must be reported. Thus, there is a great potential for multiple reports and unnecessary duplication.

In 2000 the Code of Virginia was amended to require the notification of patients beginning with diagnoses made in 2001. As of June 2002, 24,825 people were notified. VDH has received 261 responses from the public concerning the notification process. The majority of people want further information. Fifty-eight people offered further information, ten wrote to express a concern, and other responses were categorized as "other" because they concern discrete issues. Finally, twenty-five people complained about the notification process.

Dr. Woolard noted that while the number of responses may be small, the intensity of the responses is large. Thirty people called VDH to say the patient had died. The VDH letter created unnecessary emotional turmoil. Fourteen people were not aware that they had cancer. The letter was received before the follow-up visit. In some cases the doctor had told the patient that he had nothing to worry about. Rather than receiving such information from a physician with whom the patient had a rapport, this information was conveyed by a letter. For those who received the letter on a Friday after the doctor's office had closed, the weekend was spent in great anguish.

Twenty-six persons contacted VDH to say that they felt their privacy had been invaded or were concerned about the security/confidentiality of the database. Finally, five people requested that their names be removed from the registry.

Some of the negative concerns expressed include the state having someone's name in a registry, that the state cannot be trusted to protect the information sufficiently nor to use the information appropriately, and that the registry functions like a "Big Brother". Some have threatened legal action.

Dr. Woolard suggested a number of policy options. First, VDH can continue to notify patients. Second, it can increase notification time from 60 to 90 days. Finally, VDH can work to repeal the notification requirement altogether.

Mrs. Duran questioned whether VDH has a line on the form the physician signs stating that the physician has notified the patient. Dr. Woolard responded that no such line exists but added that some registry information comes from the laboratories.

Dr. Gaunt stressed the importance of the role of physicians in this process. He believes this responsibility to notify a patient he has cancer should rest with the treating physician.

Mrs. Duran echoed Dr. Gaunt's sentiment and added the thirty other state registries that exist without such a notification requirement promote the belief that the state is doing a fine job with the information it receives and that the state has a policy of recognizing the importance of physician notification of diseases. She asked whether other states require such notification and was told that the only other state with a notification requirement is Oregon.

There was discussion surrounding educating the sponsor of the 2000 bill of its difficulties. The Board would like to invite the sponsor of the bill to attend an upcoming

meeting so that Board members could discuss the problems associated with cancer registry notification. The Board would like to have the notification requirement repealed. In addition, Dr. Gaunt will discuss this matter with the Medical Society of Virginia. Some Board members mentioned that the Cancer Society and Hospital Association should be informed of the Board's desire.

A motion was made, seconded and properly carried to draft legislation to repeal the cancer registry notification language in the Code of Virginia.

Health Systems Agency and HBs 10 and 471 of the 2002 General Assembly
House Bills 10 and 471 eliminated the responsibilities of the nonfunctioning Virginia Health Planning Board and transferred them to the Board of Health. Mr. Dean Montgomery provided the Board with background information concerning the health systems agencies (HSAs) in Virginia. He provided a handout to the Board members.

Generally, the HSAs will assist the BOH in research and analysis, reports and studies as requested and provide data collection. The HSAs also develop and help to revise the SMFP. They are responsible for COPN application review and assist with shortage area designations. Finally, they conduct community needs assessments and provide technical assistance to local governments, community organizations, and other interested parties.

Each HSA is a recognized 501(c)(3) organization. They have boards of directors of differing composition and size. Three agencies have thirty board members and two of them have fifteen to twenty board members. They receive a biennial state appropriation based upon population. They also receive residual COPN money. They received about several hundred thousand dollars for the past four years due to the increase in COPN applications.

Collectively, they publish a hospital profile based upon VHI data. This profile allows them to compare hospital use rates, determine the types of procedures performed and compare regions. It allows the reader to study health service area markets as well as changes in the area such as migration patterns. The profile is published every year and is available in electronic format.

Every four years the HSAs perform a statewide survey of nursing facilities. This information is then used to create a nursing home institutional profile that highlights the community, planning district and state as a whole. This profile has determined that nursing home use rates have decreased dramatically while the demand for nursing homes is growing. Had the use rate not decreased, there would have been a need for fifty to eighty percent more nursing home beds. The reasons generally attributed for this decrease in use rate is that some care that was formerly provided by nursing homes is now being provided by assisted living centers. Also, the elderly are now healthier.

With regard to hospital demand, the state use rate is currently stable, but hospital costs are predicted to increase for three reasons. First, many hospitals were built in the 1960s-70s and the facilities are now in need of repair. Second, the population is aging. Finally,

the cost-savings achieved by transferring care from an inpatient to an outpatient setting is not likely to be as great as they have been in the past.

This decrease in cost savings will mean policy development concerning nursing home and hospital capacity will have to be carefully calibrated. Virginia will experience a more mature market. There is already significant HMO penetration, substantial reliance on outpatient savings and a growing problem of the uninsured. The current move to maximize savings by transferring more services to an outpatient setting jeopardizes hospital income streams because they may have to compete with private competitors that do not have to provide charity care.

Dr. Beales asked whether the HSAs reviewed data concerning severity of care of patients. Mr. Montgomery stated that generally this was not done but that some data the HSAs receive suggest the acuity of illness is increasing. More patients are coming from hospitals to nursing homes. The average length of stay has decreased. In the past, nursing homes accepted their fair share of Medicaid patients on a rotating basis. Now, some are not unwilling or unable to do so. Like hospitals, nursing homes are experiencing infrastructure replacement challenges. In the northern Virginia area, eighty percent of hospitals are involved in construction activities that dwarf the initial cost of the hospital. This trend is expected to continue. Hospitals will likely have to raise a lot of money and will likely consider moving to more affluent neighborhoods. Thus, there is a need to revise the SMFP.

Mrs. Duran highlighted a number of opportunities and threats. The increase in the uninsured will require a broadened safety net. The building boom will likely result in an increase of private rooms thereby raising insurance rates. Small employers won't be able to handle these increases and therefore the number of uninsured will increase.

Mr. Montgomery responded that partnering with the private sector would likely result in an ability for the public sector to respond to some of the threats mentioned.
Dr. Beales noted that consumers would likely have greater burdens placed upon them to be responsible with regard to lifestyle choices they make that result in adverse health outcomes.

Our Health

Mr. Dave Sweeney provided the Board with an introduction to the activities of a program in Winchester called "Our Health". The purpose of the program is to improve the health of the community by bringing existing organizations together in one building. The organizations would retain their autonomy but work with one another to decrease duplication of services. The community to be served includes Clark and Frederick counties as well as the City of Winchester.

Valley Health System (VHS) facilitated the creation of Our Health. The project was spearheaded by a VHS needs assessment. VHS provides 100 percent of Our Health's executive management expenses.

Our Health's current priorities are to improve access to medical and dental care, foster adolescent mental health, expand healthcare screening, and develop shared grant-writing services, and to build a community services building. The community services building is a top priority. The program will locate public and private health organizations under one campus to allow for one-stop healthcare shopping. Other benefits include expanded service potential, shared staff and equipment, and other resources and the location of a permanent home for these organizations. The outcome would likely benefit the community because it would promote economic revitalization as well as a healthy workforce. Therefore, the benefits from the project would result in more than the benefits of mere co-location.

The total cost of the project is $3.8 million. VHS has pledged $1,000,000 if the community will raise $1,500,000. If the community is unable to do so, VHS pledges $500,000. One resident has pledged a $300,000 matching gift.

The project will be completed in three phases. The first phase will entail the acquisition of land. The second phase will be to renovate and expand two existing buildings. The final stage will be to construct a new building in the center of the site. The building will be located at North Cameron Street in Winchester, Virginia.

Members of the BOH were impressed with the amount of generosity in Winchester that the project demonstrated. They asked questions regarding the area's demographics. They questioned whether the matching gift was typical of the generosity displayed in Winchester. Mr. Sweeney informed the Board that Winchester and the surrounding area was known as having a very caring community. Dr. Gaunt echoed this sentiment and added the project was an example of the generosity found in the community.

Dr. Lanier suggested the members of Our Health might want to expand its connections by partnering with academic institutions to provide practical training for its students.

Follow Up of VDH Mandated Services and Activities

Mr. Hilbert began his presentation by outlining the history of the legislative initiatives. At the April meeting in South Hill, the Board expressed its desire to provide input for development of health-related legislation early in the process, before policy decisions were made. At the May meeting the Board discussed a number of ideas for possible legislation and asked VDH staff to provide some additional information concerning several potential legislative proposals so that it could make some final decisions at this meeting.

He reminded the Board that in addition to its legislative process there was a simultaneous legislative process taking place within VDH. The VDH process is structured by the Governor's legislative package for the 2003 General Assembly Session. The Governor will likely not approve bills that do not fall within his stated criteria. VDH will share with the BOH the list of ideas for legislation that senior management chooses to pursue. Any decisions that the Board makes concerning legislative proposals will be taken into

consideration by VDH management, along with all of the other suggestions made by VDH staff.

To the extent there are any legislative initiatives that the Board is interested in that VDH decides not to include in its recommendations to the Secretary, the Board is free and authorized to pursue those items independently by meeting with the Secretary and/or legislators, etc. VDH will assist the Board by providing factual information in order to develop those items. The Board needs to understand, however, that situations could potentially arise where legislation of interest to the Board may be in conflict with the Administration's position on that subject. In that case, VDH staff would have to defer to the Administration's position and would have to limit the type of assistance provided.

Mr. Hilbert concluded his presentation by offering his assistance in the Board's legislative development process.

Finally, the BOH reviewed its legislative initiatives that it wanted to pursue. The Board wants to amend the Code section that authorizes the sharing of immunization information through a central registry. The amendment would require the registry to include data elements consistent with the CDC core data elements. The Board was in agreement that it wanted to pursue this initiative so long as there was no fiscal impact. Mrs. Duran added that the suggested language should be clear that the doctor is required to report and that this requirement does not extend to health plans.

The Board also wants to proceed with increasing nursing facility and hospital licensing fees. Mr. Williams stated that because the federal regulations are more stringent, perhaps the Board should consider deeming compliance with state regulations if the entity could meet federal regulations. After considerable discussion on this issue, Dr. Hickey asked that Nancy return to the Board to explain the fees for state activities and that she explain the difference between licensure and certification. He would like a delineation of state and federal functions and the amount of money involved. One Board member was concerned that proceeding with this initiative would raise costs of hospitals. Another member countered that citizens will either pay as patients or as taxpayers.

The Board will proceed with changing legislation concerning criminal records checks for home care and hospice employees. Mrs. Cabral-Daniels will provide information at the next meeting regarding criminal record check requirements for assisted living facilities and adult care residences.

The Board noted unanimous consent for proceeding with the change to the Code so that autopsy reports are admissible in both criminal and civil trials.

Because the proposal to waive the toll on the Chesapeake Bay Bridge Tunnel for physicians serving this underserved area is in conflict with the bridge's bond requirements, this proposal will not be pursued.

The Board will continue efforts to have the telemedicine study language removed from the Code as there are no funds for VDH to perform this study.

The final legislative initiative that the Board would like to pursue is amending the Virginia freedom of information statute to exempt information regarding the WIC program's maximum allowable payment amount for certain food types.

One of the two initiatives that the Board will not continue is the designation of localities for teen pregnancy prevention activities. Such activity would require a budget amendment. The other is financing the minority health resolution. Because this item would likewise require a budget amendment, it will not be pursued.

Jeff Lake concluded the meeting by asking members to please read his report on childhood obesity and attempts by school systems to address this issue. He reminded them that he was available for comments. Members commented that this is an important political issue. They discussed the financial advantages of having soda machines in school versus the public health disadvantages of having such machines. They also discussed the problems associated with the school lunch program such as the noted high fat content.