Virginia Department of Health Workgroup on Local Health Department Structure and Financing

Agenda

August 7, 2023 – 1:00 p.m.
Mezzanine Conference Room, James Madison Building
109 Governor Street, Richmond VA 23219

Welcome and Introductions	Dr. Karen Shelton State Health Commissioner
Electronic Participation Policy	Joe Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs, Virginia Department of Health
Overview and Planned Approach to Follow-up	Joe Hilbert
Public Comment	
Discussion	Workgroup Members
Next Steps	Workgroup Members
Adjourn	

TITLE: Procedures for Electronic Participation in Virginia Department of Health Workgroup on Local Health Department Structure and Financing Meetings and All-Virtual Meetings

EFFECTIVE DATE: August 7, 2023

AUTHORITY: § 2.2-3708.3 of the Code of Virginia

DEFINITIONS:

The following definitions shall apply to the words used in this policy unless otherwise noted:

"Participate electronically" means participating in an in-person meeting through electronic communication from a location that is not the location advertised in the public meeting notice.

"Electronic communication" means the use of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities to transmit or receive information.

"In-person meeting" refers to a meeting that has not been approved as an all-virtual meeting pursuant to this policy. All in-person meetings must have a quorum assembled in one physical location.

"All-virtual meeting" refers to a meeting that has been approved as an all-virtual meeting pursuant to this policy. During an all-virtual meeting, all members, staff, and the public may participate through electronic communication. No more than two members may be assembled in one physical location that is not open to the public.

PARTICIPATING ELECTRONICALLY DURING IN-PERSON MEETINGS:

Process for making requests

Each individual member shall request approval to participate electronically from the Chair, and staff. Each request shall state a specific reason for electronic participation. Electronic participation is limited to the following reasons:

1. A member is unable to attend the meeting because of a temporary or permanent disability or other medical condition that prevents their ability to physically attend such meeting,
2. A medical condition of a family member of a member requires the member to provide care that prevents their physical attendance,
3. A member's principal residence is more than 60 miles from the location of the meeting, or
4. A member is unable to attend due to an emergency or personal matter – the specific nature of which shall be shared with the Chair

If a member is requesting to participate electronically pursuant to reasons 1, 2, or 3, they must make their request 10 business days before the meeting. The Chair may make exceptions to this rule in his or her discretion.

If a member is requesting to participate electronically pursuant to reason 4, they may make their request up to 24 hours before the scheduled start time of the meeting. The Chair may make

exceptions to this rule in his or her discretion.

Other requirements

Whenever an individual member is to participate electronically, the following conditions must be present:

1. A quorum of the Virginia Department of Health Workgroup on Local Health Department Structure and Financing must be physically assembled at the primary or central meeting location.
2. There must be arrangements for the voice of the remote participant to be heard by all persons at the primary or central meeting location.

If a member is participating electronically, the minutes shall reflect which of the four reasons the member has given.

If a member is participating electronically pursuant to reason 4 (above), the minutes shall also include the specific nature of the personal matter cited by the member. Furthermore, such electronic participation by any one member is limited to by law to two of the Board's meetings or 25% of the meetings per year, whichever is greater. There is no limit to the number of times a member may participate electronically due to other allowable reasons.

Automatic approval; vote required if challenged

Individual electronic participation from a remote location shall be approved unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act. If a member's participation from a remote location is challenged by one or more members, then the Virginia Department of Health Workgroup on Local Health Department Structure and Financing shall vote whether to allow such participation and the results of such vote shall be recorded in the minutes with specificity.

If a member is approved to participate electronically the meeting minutes shall reflect the remote location from which the member participated; however, the remote location need not be open to the public and may be identified by a general description.

ALL-VIRTUAL MEETINGS:

The Virginia Department of Health Workgroup on Local Health Department Structure and Financing may convene all-virtual meetings in accordance with the Virginia Freedom of Information Act. An indication of whether a meeting will be in-person or all-virtual will be included in the meeting notice. The type of meeting will not be changed once the notice is published unless the Virginia Department of Health Workgroup on Local Health Department Structure and Financing provides a new notice in accordance with the Virginia Freedom of Information Act.

At the third regular meeting of the calendar year, the Virginia Department of Health Workgroup on Local Health Department Structure and Financing shall discuss potential dates for all-virtual meetings during the following calendar year based on the planned workload of the Board and the schedules of the members. The members may then, by consensus, suggest

two meetings that may be held as all-virtual meetings.

At least 15 business days prior to any regular or special meeting, the Chair shall confirm with staff whether a meeting will be an in-person meeting or an all-virtual meeting. Staff will then communicate the type of meeting to the other members and the public. There is a strong preference to follow the suggested schedule created each calendar year. However, the Chair may, to the extent allowed by law, change a scheduled in- person meeting to an all-virtual meeting in extenuating circumstances. The Chair may also change a scheduled all-virtual meeting to an in-person meeting at the request of other members and/or staff.

The Virginia Department of Health Workgroup on Local Health Department Structure and Financing may not convene an all-virtual public meeting (i) more than two times per calendar year or 25 percent of its meetings held per calendar year rounded up to the next whole number, whichever is greater, or (ii) consecutively with another all-virtual public meeting.

CLARIFICATIONS:

The limits on electronic participation from a remote location due to emergencies or personal matters (reason 4) are separate from the limits on all-virtual meetings and will be counted separately. If a member's request to participate electronically is disapproved, said member may still continue to monitor the meeting from the remote location, but may not participate and may not be counted as present for the meeting.

Three or more members may be gathered in one location during an all-virtual meeting so long as that location is open to the public.

JCHC Policy Options – Structure and Financing of Local Health Departments

OPTION 1: The JCHC could introduce legislation to amend the Code of Virginia to require LHDs to ensure the availability of clinical services, either by the LHD or by other providers, facilitate access to and linkage with clinical care, as well as address chronic disease and injury prevention. The legislation should include an enactment clause directing VDH to update the Local Government Agreements to reflect these changes.

OPTION 2: The JCHC could introduce a Section 1 bill directing VDH to design a state performance management process for each LHD, with the goals of assessing the ability of each LHD to meet minimum capacity requirements, assisting in continuous quality improvement, and providing a transparent accountability mechanism to ensure public health functions are being met.

OPTION 3: The JCHC could introduce a Section 1 bill directing VDH to develop and submit a plan by November 1, 2023 for the development of a centralized data system that will enable VDH to access necessary data from all LHDs across departments to support LHD assessment and performance management, as well as enable greater data sharing with stakeholders and the public.

OPTION 4: The JCHC could introduce a budget amendment to provide additional funding to VDH for loan repayment programs for LHD staff.

Additionally, a targeted salary increase for LHD employees would assist with both recruitment and retention. This would not only improve satisfaction for tenured employees who are frustrated by their stagnant wages, but also improve the salary range LHDs can offer to candidates during the hiring process. While doing so might not allow LHDs to match or beat industry salary rates, it would make their offers more competitive, in addition to state benefits.

OPTION 5: The JCHC could introduce a budget amendment to fund targeted increases for LHD staff base salaries to align with current industry salary benchmarks.

OPTION 6: The JCHC could introduce a budget amendment directing VDH to create regional operations and facilities management positions to assist LHDs and providing funding for these staff.

OPTION 7: The JCHC could introduce a Section 1 bill directing VDH to require all health districts to participate in the CHA/CHIP process, in coordination with the state health assessment process and local health system Community Health Needs Assessments. The legislation should include an enactment clause directing VDH to update the Local Government Agreements to reflect these changes.

OPTION 8: The JCHC could introduce a Section 1 bill directing VDH to determine the funding necessary to provide sufficient communications capacity across all health districts. VDH should submit the funding estimate to the Chairs of the House Appropriations Committee and Senate Finance and Appropriations Committee by August 1, 2023

OPTION 9: The JCHC could introduce a Section 1 bill directing that VDH track cooperative budget funding per capita, compare that funding to the identified needs of each LHD, and make appropriate adjustments as additional funding is made available.

OPTION 10: The JCHC could introduce a Section 1 bill directing VDH to update state regulations for environmental health services to increase inspection fees and adjust them based on the type of establishment being inspected, to account for the typical time it takes to conduct the inspection.

OPTION 11: The JCHC could introduce a Section 1 bill directing VDH to adopt regulations to implement a system of civil monetary penalties on facilities in violation of state environmental health regulations.

VDH Workgroup on Structure and Financing of Local Health Departments

Workgroup Meeting

August 7, 2023

Overview and Planned Approach

Workgroup Members

Dr. Elaine Perry – Director, Richmond/Henrico Health District

Reisa Sloce – Director, Lenowisco and Cumberland Plateau Health Districts

Jim Taylor – Deputy County Administrator, Hanover County (Virginia Association of Counties)

Joe Flores – Director of Fiscal Policy, Virginia Municipal League

Michael Jackson – Director of Government and Legislative Affairs, Virginia Community Healthcare Association

Rufus Phillips – CEO, Virginia Association of Free and Charitable Clinics

Ben Barber – President-elect, Virginia Public Health Association

Leah Mills – Deputy Secretary of Health and Human Resources

Bob Hicks – Deputy Commissioner for Population Health and Preparedness, Acting Deputy Commissioner for Community Health Services – Virginia Department of Health

Joe Hilbert – Deputy Commissioner for Governmental and Regulatory Affairs – Virginia Department of Health

2022 JCHC Study

The JCHC Study on Structure and Financing of Local Health Departments identified eleven policy options pertaining to:

- Clinical services, and linkages to care, provided by local health departments
- Performance management process
- Centralized data system
- Funding for loan repayment as staff retention incentive
- Funding for targeted staff salary increases
- Funding for regional operations and facilities management positions
- Community health assessments and community health improvement plans
- Communications capacity across all health districts
- Cooperative budget funding per capita
- Environmental health inspection fees
- Civil monetary penalties for violations of environmental health regulations

Request for Follow-up by VDH

- JCHC requested VDH to create a workgroup to prioritize the policy options, identify any additional options, provide recommendations on necessary legislation or budget amendments, along with cost estimates for any recommendations and report back to the General Assembly by 10/1/23.
- Workgroup should include the Office of the Secretary of Health and Human Resources, Virginia Municipal League, and Virginia Association of Counties
- May also include others such as the Virginia Public Health Association and the Virginia Community Healthcare Association

Presentation Outline

Background

Framing of Issues

Discussion Questions

Next Steps

VDH Steering Committee

Bob Hicks – Deputy Commissioner for Public Health and Preparedness, and Community Health Services

Angela Tillery - Assistant Deputy Commissioner for Community Health Services

Jeff Lake – Senior Advisor for Community Health Services

Dr. Kyndra Jackson – Director of Public Health Nursing

Ashley Reed – Director of Business Process, Community Health Services

John Ringer – Director of Public Health Planning and Evaluation

Dr. Elaine Perry – Director, Richmond/Henrico Health District

Dr. Cynthia Morrow – Director, Roanoke/Alleghany Health District

Dr. Scott Spillmann – Director, Pittsylvania/Danville, Southside Health Districts

Jon Richardson – Director, Eastern Shore Health District

Reisa Sloce – Director, Lenowisco and Cumberland Plateau Health Districts

Paul Brumund – Chief Operating Officer, Norfolk and Virginia Beach Health Districts

Joe Hilbert – Deputy Commissioner for Governmental and Regulatory Affairs

Steering Committee Consensus to Prioritize Certain JCHC Policy Options

Option 7 - Directing VDH to require all health districts to participate in the CHA/CHIP process, in coordination with the state health assessment process and local health system Community Health Needs Assessments. The legislation should include an enactment clause directing VDH to update the Local Government Agreements to reflect these changes.

Option 2 - Directing VDH to design a state performance management process for each LHD, with the goals of assessing the ability of each LHD to meet minimum capacity requirements, assisting in continuous quality improvement, and providing a transparent accountability mechanism to ensure public health functions are being met.

Option 9 - Directing that VDH track cooperative budget funding per capita, compare that funding to the identified needs of each LHD, and make appropriate adjustments as additional funding is made available.

Initial Feedback from Secretary of Health and Human Resources

- **Explore ways to access to, and linkages with, clinical care by local health departments (Option 1)**
- **Use the JCHC findings as an opportunity to reimagine the future role and priorities of local health departments**
- **Review all of the JCHC policy options**

Identify and Target Services that are a Priority for Diverse Parts of the State

Related to JCHC Policy Option 7

Each Health District will undertake a community health assessment with community partners, including hospitals and business owners, as well as a community health improvement plan that will prescribe the objectives necessary outline steps to achieve the improvement plan

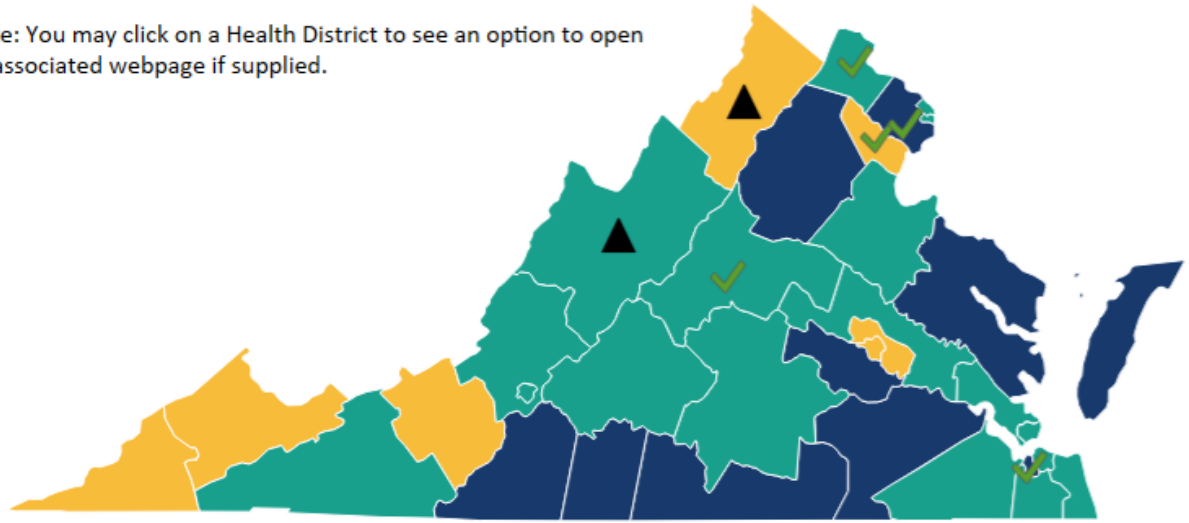
VDH proposes to include the Community Health Assessment and Community Health Improvement Plan in local government agreements to assure this is done statewide

Health District Overall CHA/CHIP Progress

Status (last updated 6/1/2023)

- CHA Complete/CHIP in Progress in Past 5 Years
- CHA In Progress
- Not Started

Note: You may click on a Health District to see an option to open its associated webpage if supplied.



Source: Virginia Department of Health, Center for Community Health Improvement, Health District CHA/CHIP Progress Report

* Black triangle indicates the CHA is led by the hospital system. Green check indicates accreditation.

Identify and Target Services that are a Priority for Diverse Parts of the State

Workgroup Discussion Questions

How should the results of community health assessments and the provisions of community health improvement plans be used by local health departments and their community partners?

How can we connect the Community Health Assessment work on understanding local needs and assets to the local government agreement process?

Improve Accountability of Local Health Departments to Funders and Public

Related to JCHC Policy Option 2

Develop and implement a set of public health metrics used to measure and improve the performance of LHDs statewide

VDH will utilize the experience of states such as Florida that has a mature performance management system for its LHDs

VDH will also examine different options for how to better align LHD staffing with current public health needs and availability of the workforce

Improve Accountability of Local Health Departments to Funders and Public

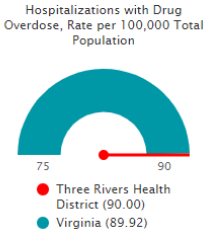
VDH has many existing many existing data sets and dashboards which could aid in this effort

The Virginia Community Health Improvement Portal – can quickly create maps and table for over 100 indicators for every locality or health district in Virginia

Drug Overdose Hospitalizations, Rate per 100,000 Population

This indicator reports the number and rate of hospital inpatient stays due to drug overdose, per 100,000 population. A drug overdose is accidentally or intentionally taking too much of a substance, whether it's prescription, over-the-counter, legal, or illegal, that is more than the recommended amount of a drug or enough to have a harmful effect on one's body's functions. An overdose can lead to serious medical complications, including death. The overdose epidemic is a widespread public health emergency, contributing to an increase in hospitalizations, deaths, and outbreaks of infectious diseases linked to intravenous drug use. It results in heavy economic costs from death, lost productivity and avoidable expenditures.

Report Area	Total Population	Hospitalizations with Drug Overdose	Hospitalizations with Drug Overdose, Rate (per 100,000 Total Population)
Three Rivers Health District	142,227	128	90.00
Essex County, VA	10,943	12	109.66
Gloucester County, VA	37,459	38	101.44
King and Queen County, VA	6,942	8	115.24
King William County, VA	17,641	13	73.69
Lancaster County, VA	10,618	6	56.51
Mathews County, VA	8,766	9	102.67
Middlesex County, VA	10,569	14	132.46
Northumberland County, VA	12,069	7	58.00
Richmond County, VA	9,071	8	88.19
Westmoreland County, VA	18,149	13	71.63
Virginia	8,590,563	7,725	89.92



Improve Accountability of Local Health Departments to Funders and Public

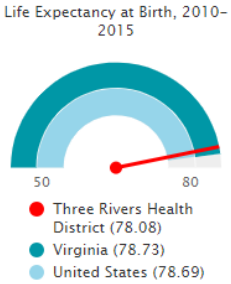
Virginia Community Health Improvement Portal

Life Expectancy by Locality

This indicator reports the average life expectancy at birth. Life expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population. Life expectancy takes into account the number of deaths in a given time period and the average number of people at risk of dying during that period, allowing us to compare data across census tracts with different population sizes.

Within the report area, the average life expectancy at birth is 78.08 of the total population.
Note: Data are suppressed for areas with fewer than 5,000 total population (pooled) during the study period.

Report Area	Total Population (2010-2015)	Life Expectancy at Birth (2010-2015)
Three Rivers Health District	140,931	78.08
Essex County, VA	11,151	78.01
Gloucester County, VA	37,001	78.05
King and Queen County, VA	7,106	77.95
King William County, VA	16,097	76.05
Lancaster County, VA	11,129	78.43
Mathews County, VA	8,880	82.47
Middlesex County, VA	10,717	78.24
Northumberland County, VA	12,304	78.59



Improve Accountability of Local Health Departments to Funders and Public

Both Florida and Oregon have examples of performance management systems for local health departments – but they are two different types of systems

Florida - A reporting and data tool more focused on public health outcomes

Oregon – part of a larger state performance measurement / management system with a focus on SMART goals for government

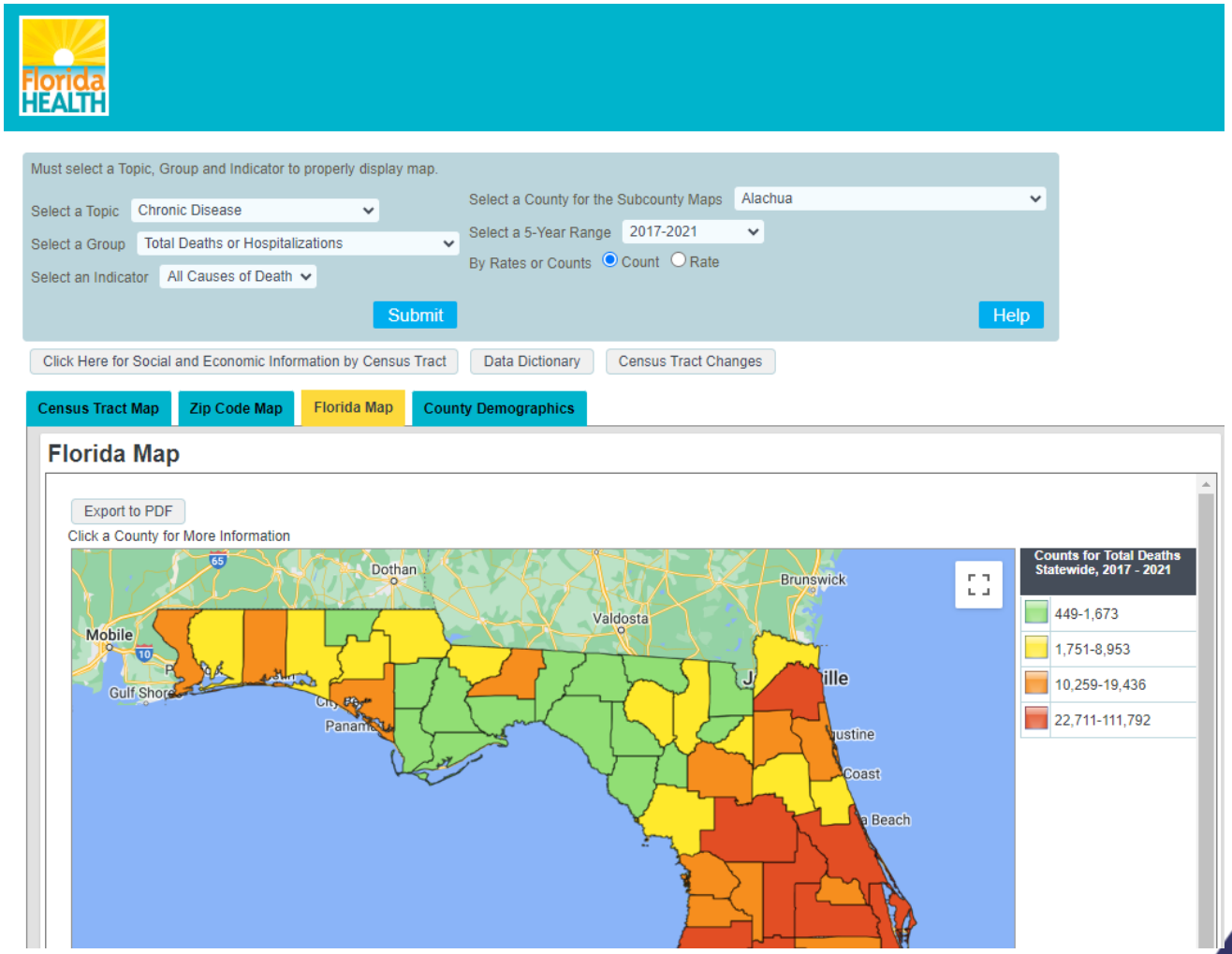
Oregon Public Health Accountability Metrics

Table 1. Public Health Accountability and Developmental Metrics

PART 1: ACCOUNTABILITY METRICS

Health Outcome Measure	Local Public Health Process Measures		
Communicable Disease Control			
Percent of two-year olds who received recommended vaccines	Percent of Vaccines for Children clinics that participate in the Assessment, Feedback, Incentives and eXchange (AFIX) program		
Gonorrhea incidence rate per 100,000 population	Percent of gonorrhea cases that had at least one contact that received treatment	Percent of gonorrhea case reports with complete priority fields	
Prevention and Health Promotion			
Percent of adults who smoke cigarettes	Percent of population reached by tobacco-free county properties policies	Percent of population reached by tobacco retail licensure policies	
Prescription opioid mortality rate per 100,000 population	Percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program (PDMP) Database		
Environmental Health			
Percent of commuters who walk, bike, or use public	Local public health authority participation in leadership or planning		

Florida Health Charts



Improve Accountability of Local Health Departments to Funders and Public

Workgroup Discussion Questions:

How can we create a structure that is flexible yet assures the public's health is protected?

What types of public health outcomes and outputs should be reported? What of these measures should LHDs be held accountable for?

What is the capacity of the local community to provide clinical services or to provide linkages to clinical services?

To what extent should the revenue-generating potential of a service be a consideration as to whether or not it is provided by a local health department?

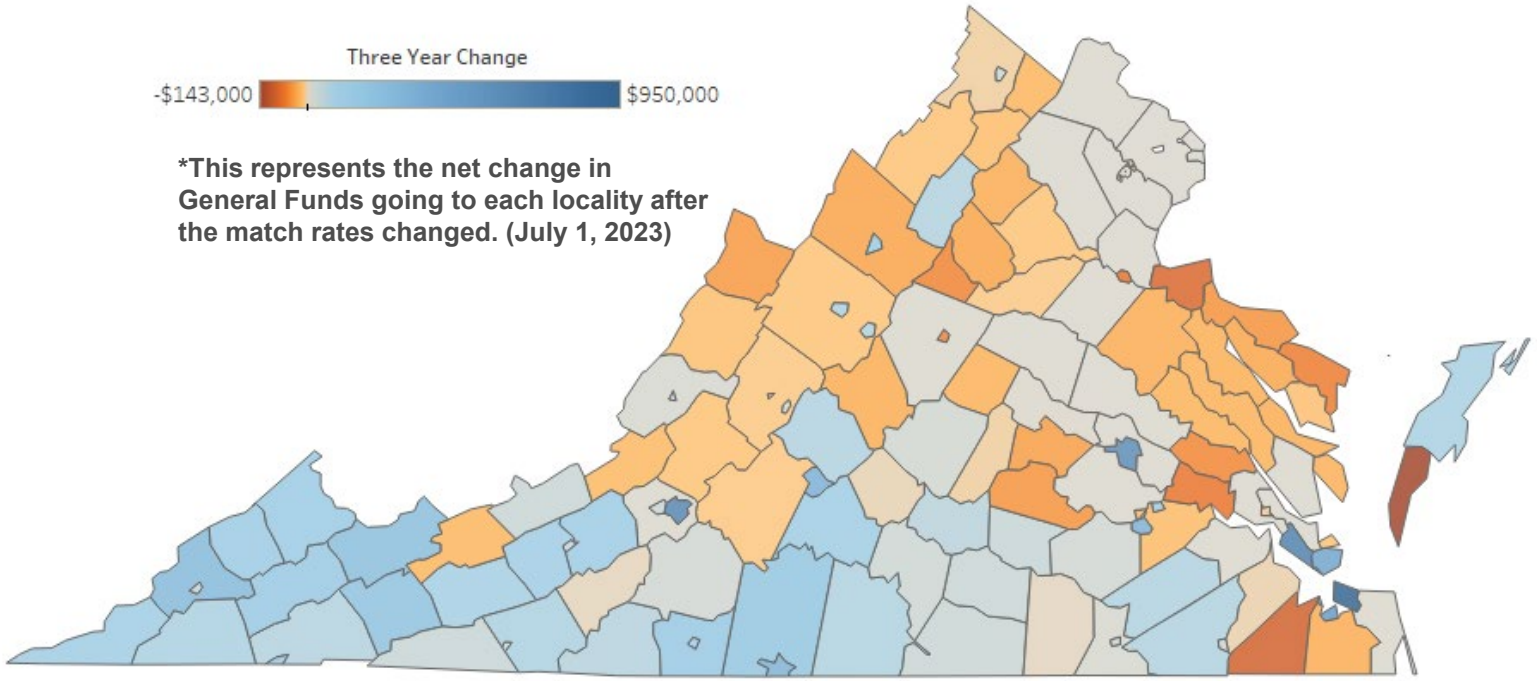
Modernize Allocation of General Funds to Local Health Departments

Related to JCHC Policy Option 9

VDH relies on a historical funding pattern that has not changed substantially in decades

One option is to request approval and funds to provide LHD with general fund allocations that do not require local matching funds. Target unmatched funds to support disadvantaged communities like Peterburg and other similarly situated LHDs across the state

Impact of Match Rate Change by Locality



*This represents the net change in General Funds going to each locality after the match rates changed. (July 1, 2023)

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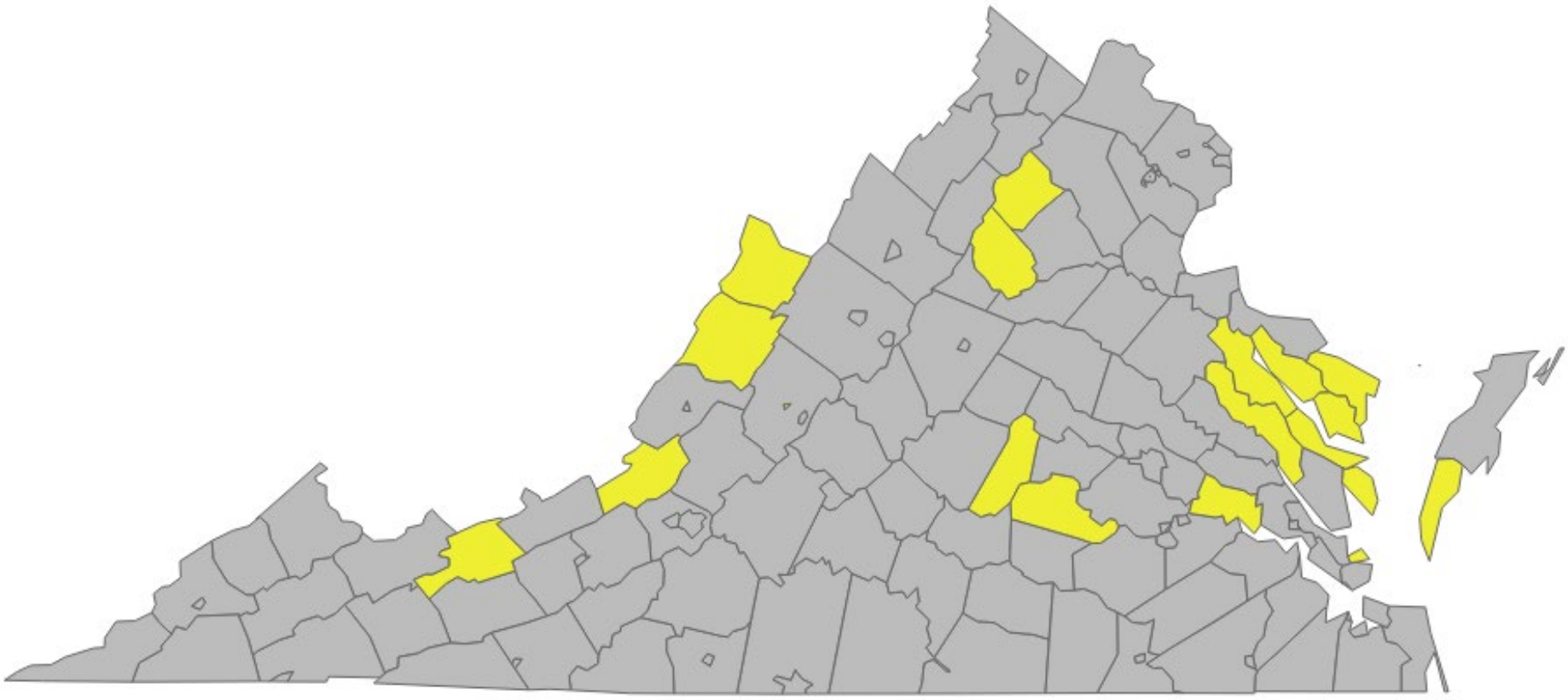
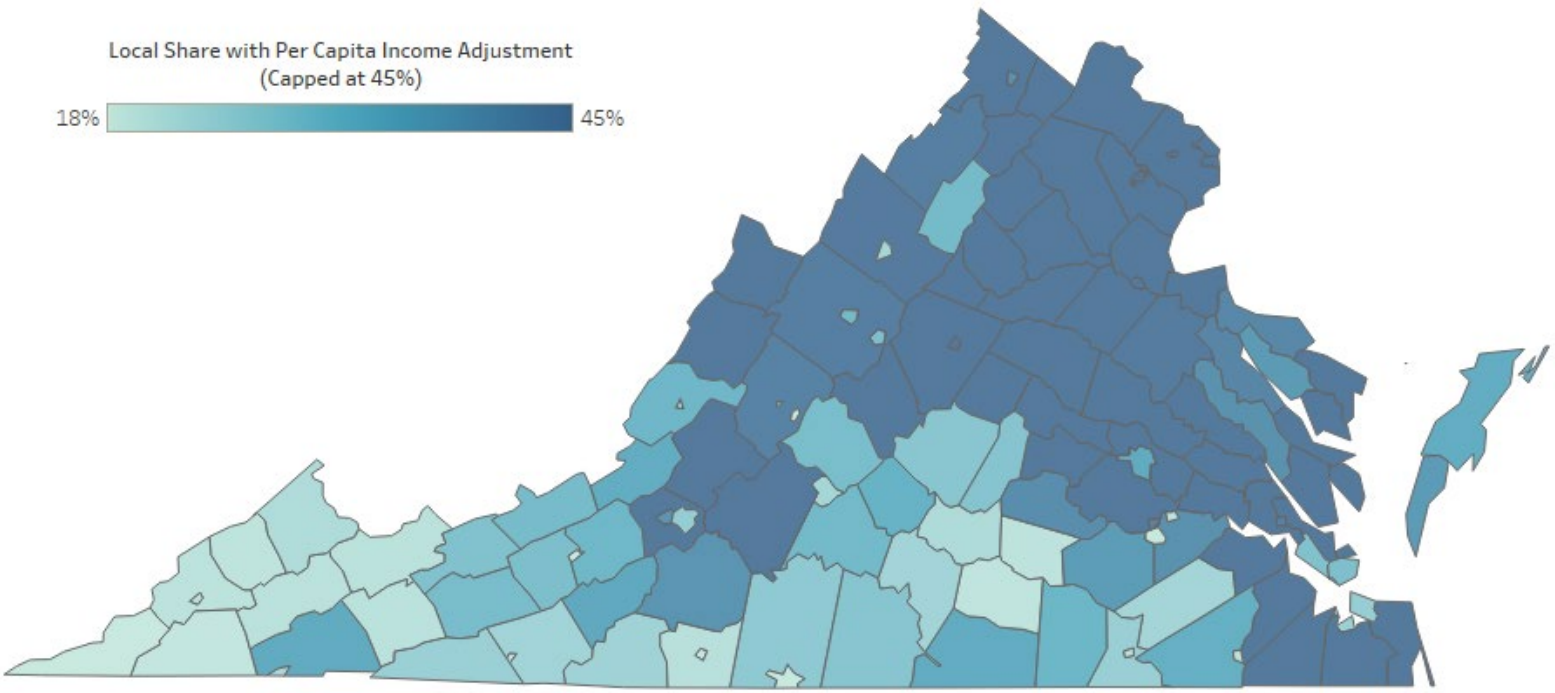
Small Localities with Increased Match Rates



Local Share as of July 2023



Local Health Districts COOP Budget Contributions

Local Health Districts with no contribution above COOP Budget

Central Virginia
Central Shenandoah
West Piedmont
New River
Crater
Chickahominy
Eastern Shore
Hampton
Peninsula
Portsmouth

Localities with Minimum 18% Match Rate Who Do Not Pay any Additional Funds into COOP Budget

Buena Vista

Martinsville

Petersburg

Radford

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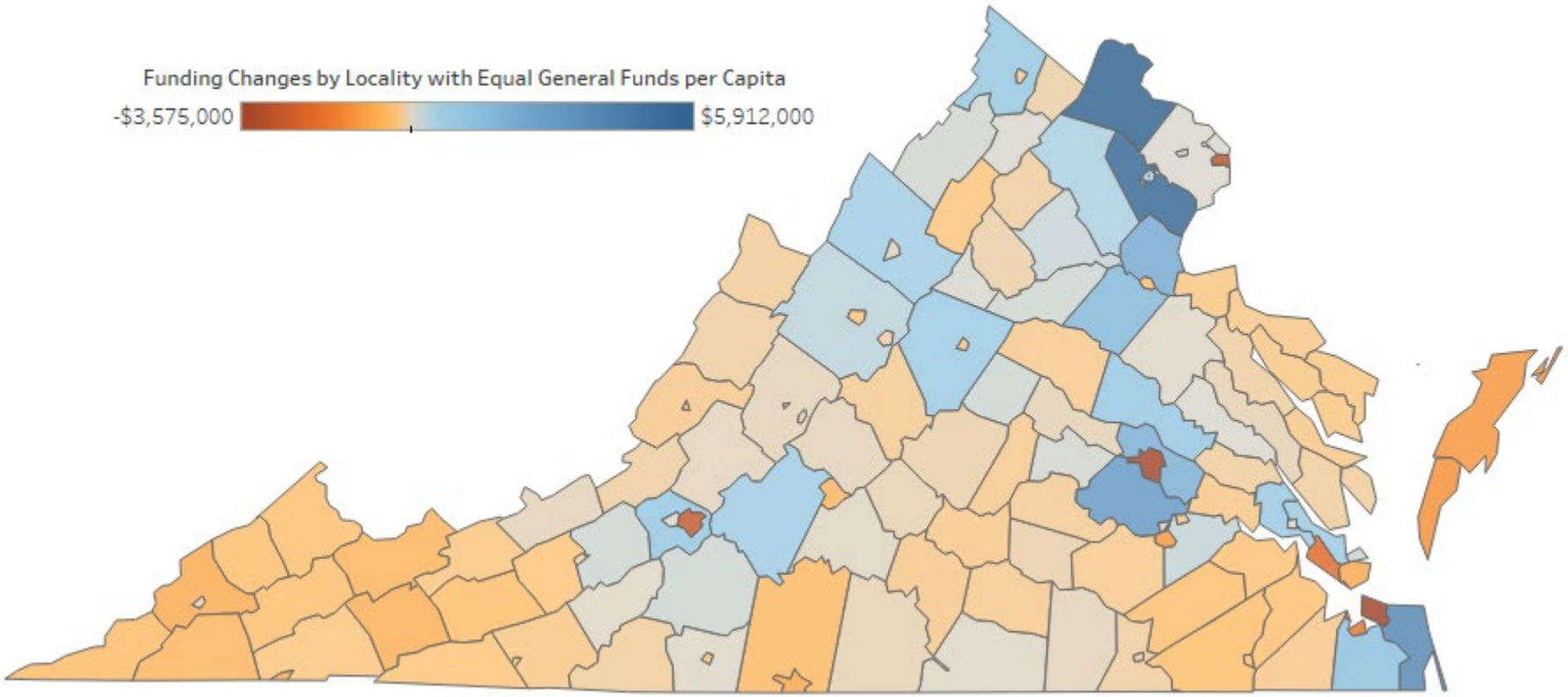
Impact of Moving to Per Capita Funding



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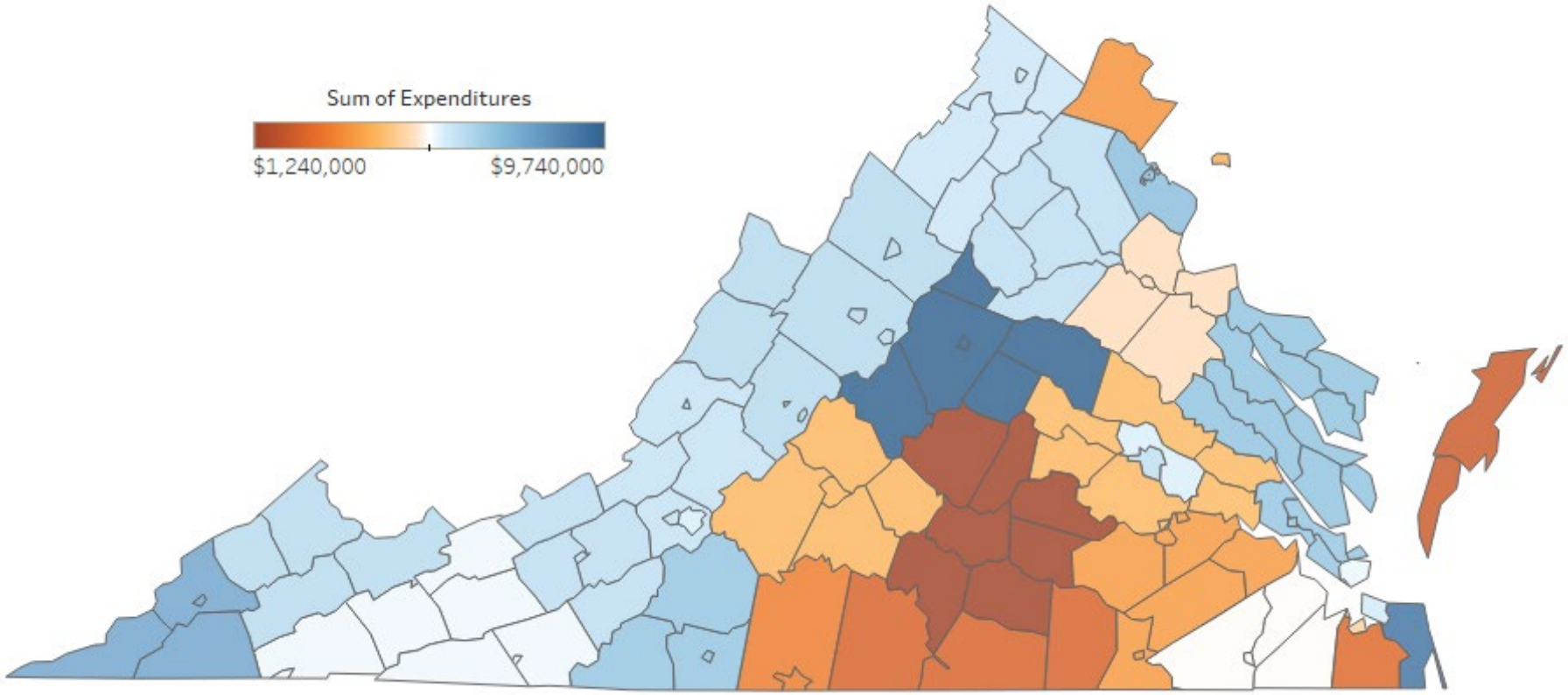
Federal Fund Expenditures by Health District (FY23)



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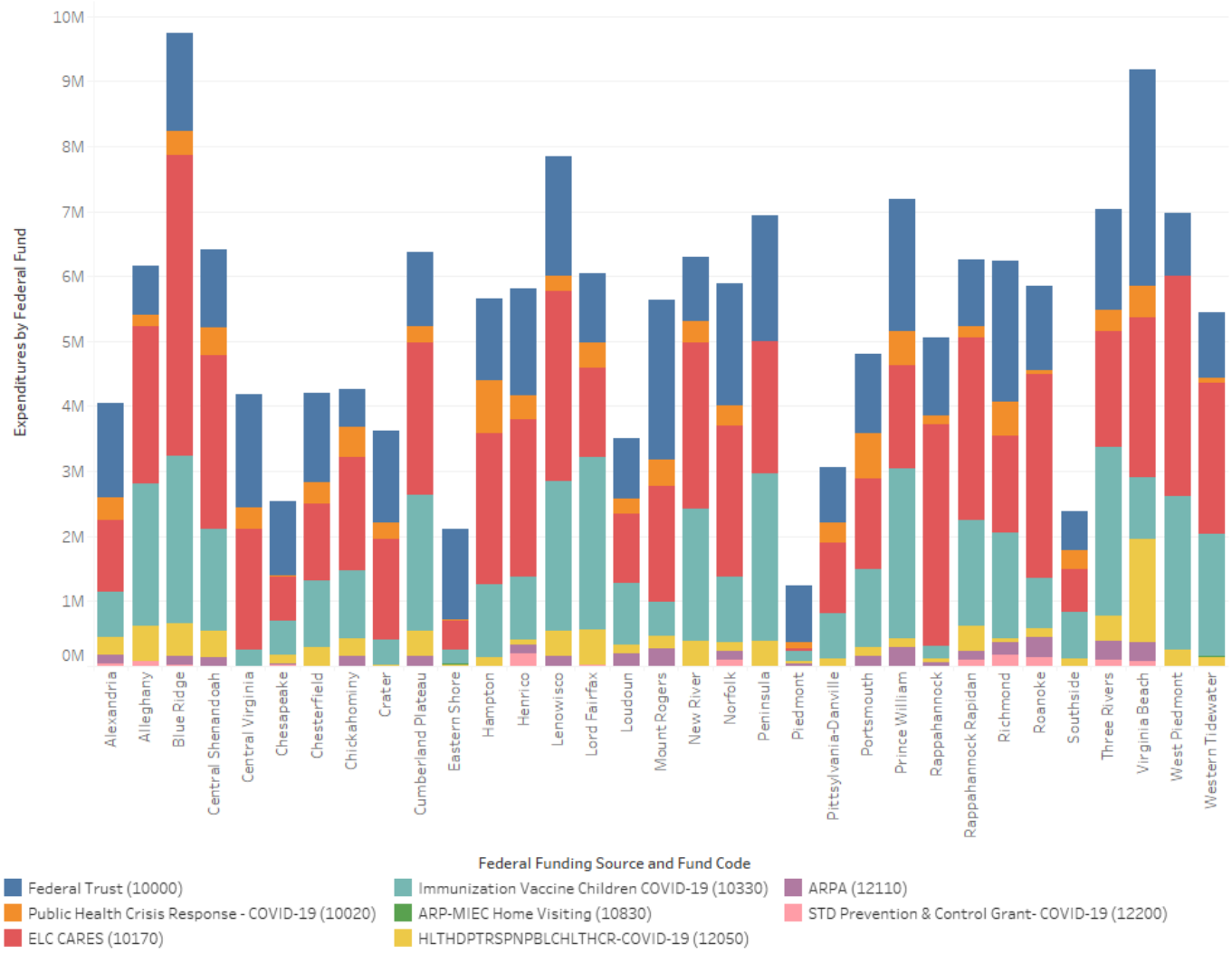
Federal Fund Expenditures by Health District (FY23)



Modernize Allocation of General Funds to Local Health Departments

Workgroup Discussion Questions:

What would a needs-based General fund allocation model within the COOP budget look like and what components or variables would it contain?

What steps should VDH take to identify criteria that would be used to implement a need-based model?

Next Steps

Receive and incorporate feedback from workgroup members

Schedule next workgroup meeting and develop agenda

Continue review/analysis of financial, budgetary, staffing and community health assessment data

Determine information to be shared with workgroup; determine additional meetings needed

Begin work on draft report to General Assembly

Questions?