REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

The Operation and Services of the Department of Health

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Report of the
Joint Subcommittee Studying the
Operation and Services of
the Department of Health
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
March, 1984

To: Honorable Charles S. Robb, Governor of Virginia,
and
The General Assembly of Virginia

A. Origin of the Study

The Joint Subcommittee Studying the Operation and Services of the Department of Health was authorized to conduct its study by House Joint Resolution No. 11 agreed to during the 1982 Session of the General Assembly. The resolution may be found in Appendix A of this report.

House Joint Resolution No. 11, 1982 requested that the Joint Subcommittee:

1. Study the operation of the Department of Health and the health care services administered by the Department of Health.

2. Review all services administered and regulated by the Department and consider whether such services are appropriately administered and regulated.

Appointed to serve on the Joint Subcommittee were: Senators Adelard L. Brault of Fairfax, Vice-Chairman, Thomas J. Michie, Jr., of Charlottesville, and Edward E. Willey of Richmond; Delegates Franklin M. Slayton of South Boston, Chairman, Joseph P. Crouch of Lynchburg, Jay W. DeBoer of Petersburg, Alson H. Smith, Jr., of Winchester, and Warren G. Stambaugh of Arlington.

B. Background and Issues of the Study

The Department of Health in Virginia is a centralized organization employing over 3,600 people and directing approximately 134 local health departments. For this year alone, the state appropriations for the Department exceed $700 million. The Department of Health plays a necessary and vital role in determining solutions to the public health problems in Virginia. This role has become comprehensive in recent years and now impacts on the lives of every citizen of the Commonwealth.

The appropriations designated for health care programs and public health services in Virginia have increased dramatically in the last ten years. If this funding is allowed to continue to increase unchecked, the Commonwealth will experience serious fiscal problems. Although the increases in requests for funds have been pervasive among the programs administered by the Virginia Department of Health, the Medicaid Program appears to be responsible for a large proportion of the budget increases. It must be noted, however, that although the Medicaid Program constitutes approximately 80% of the Department's budget, this program is only one "office" in the Department which encompasses eight "offices" and dozens of programs. Questions raised by the tight money situation in the Commonwealth in relationship to the need to contain costs and the appropriate role of the Department of Health are:

1. Given the broad role of the Department of Health and the size of the funds administered by it, is the Medicaid Office properly located in order to provide for the most cost-efficient operation of the program?

2. What effects would the relocation of the Medicaid Office have on the Department's capability to provide services, the number of enrolled providers and the availability and effectiveness of services to recipients?

The growth of government's role in promoting health care for the masses during the last ten to twelve years has created an atmosphere of expectancy - everyone expects to be cared for, at public expense, during old age, catastrophic illness or personal crisis. Complicated reimbursement systems have also created the expectancy of profit - everyone expects to "work the system" either through legal manipulation of the circumstances or, in extreme cases, fraud. The recent cuts in federal appropriations for health care programs and the federal initiative to return the responsibility for such programs to the states have initiated efforts to reevaluate the state's role in its human services delivery. Many programs are being eliminated or curtailed. These circumstances raise the following questions:

1. Is the Virginia Department of Health fulfilling its proper role as a public health agency, i.e., providing services that cannot or will not be provided by the private sector; or has the Commonwealth of Virginia interjected itself unnecessarily and inappropriately into the domains of the private sector?

2. How should the State prioritize its health services for budgetary and administrative purposes to serve its appropriate governmental interests and the citizens of Virginia?

The increases in funds have been coupled with increases in the number and complexity of the public health programs. This increase in the scope and kinds of programs has stimulated the growth of the Department and enhanced its centralized organization and regulatory role, which now covers such diverse matters as processes to sterilize bedding and control of growth of the health care industry. These regulatory activities have, in some cases, precipitated clashes between various interest groups and the Department. In this age of technology and economic stress, such clashes may be the inevitable result of the Department's performing its statutory role conscientiously. Conversely, these clashes may be the result of legitimate concerns resulting from the application of uniform requirements on localities in which conditions differ widely. The Department's increased regulatory activities and the resistance to these activities on the part of some localities raise these questions:

1. What is the proper role for the State Department of Health vis-a-vis the local departments of health?

2. What is the appropriate regulatory posture of the State Department of Health in its relationship to local policies?

C. Structure of the Department

The Virginia Department of Health consists of eight "offices" and twenty "divisions." The eight offices are:

1. Office of Medical Assistance;

2. Office of Employee Relations Management (Personnel);

3. Office of the Medical Examiner;

4. Office of Administration and Staff Services (Fiscal);

5. Office of Health Planning and Resources Development;

6. Office of Health Protection and Environmental Management;

7. Office of Management for Community Services (regional and local departments); and

8. Office of Health Care Programs.

Within the Office of Employee Relations Management are the Division of Personnel Practices, the Division of Classification/Compensation Management, the Division of Equal Employment Opportunity and the Division of Employment Services. The Office of the Chief Medical Examiner subsumes the Division of Medical Examiner Services and the regional offices

of the Medical Examiner.

Within the Office of Administration and Staff Services are five divisions:

1. Division of Health Education and Information;

2. Division of Purchasing and General Services;

3. Division of Fiscal and Accounting Services;

4. Division of Internal Audit; and

5. Division of Staff Development.

Within the Office of Health Planning and Resources Development are six divisions:

1. Division of Vital Records and Health Statistics;

2. Division of Resources Development;

3. Division of Health Planning;

4. Division of Emergency Medical Services;

5. Division of Medical and Nursing Facilities; and

6. Division of Data Processing.

Within the Office of Health Protection and Environmental Management are four divisions:

1. Division of Water Programs;

2. Division of Solid and Hazardous Wastes;

3. Division of Health Hazards Control; and

4. Division of Epidemiology.

The Office of Management for Community Health Services administers the five regional health departments and the 134 local health departments, but does not contain any "divisions."

The Office of Health Care Programs includes three divisions:

1. Division of Family Health Services;

2. Division of Dental Health; and

3. Division of Nursing.

The Health Department in Virginia is administered by the Commissioner of Health, the Deputy Commissioner and eight executives, who are either assistant commissioners or at the rank of an assistant commissioner in terms of responsibilities.

Both the Commissioner and the Deputy Commissioner must be physicians as required by statute (see §§ 32.1-17 and 32.1-22 of the Code of Virginia). The Chief Medical Examiner must be an attorney as well as a physician as required by § 32.1-278 of the Code of Virginia. As the title would indicate, all medical examiners are required to be doctors (see § 32.1-282 of the Code).

At this time, two of the other executive officers of the Department of Health are physicians, as are the directors of the divisions of epidemiology and family health services and the maternal and child health programs. Also, all regional directors are physicians at present.

The following list, although not exhaustive, provides a summary of the functions of the Department:

1. Medicaid
2. Health Planning
    a. certificate of need
    b. statewide emergency medical care system
    c. development of perinatal services plan
3. Regulation of Sewage Disposal
4. Regulation of Public Water Supplies
5. Licensing and Inspection of:
    a. hospitals
    b. nursing homes
    c. blood banks
    d. home health agencies
    e. hospices
6. Permitting of:
    a. midwives
    b. emergency medical service vehicle agencies
    c. septic tanks
    d. sanitary landfills
    e. other solid waste disposal facilities
    f. migrant labor camps
    g. processes used to sanitize or sterilize bedding or upholstered furniture
7. Establishing Sanitary Conditions for:
    a. public gathering places
    b. service stations
8. Control of:
    a. radioactive material
    b. toxic substances
9. Setting of Health Standards for:
    a. marinas
    b. vector control

c. closing of bodies of water

10. Collecting of All Kinds of Vital Statistics:

    a. birth certificates

    b. adoptions

    c. death certificates

    d. marriages

    e. divorces

    f. annulments

    g. changes of name

    h. acknowledgement of paternity

    i. change of sex

    j. fetal deaths

    k. permits for disinterment and reinterment

    l. out-of-state transit permits for dead bodies

    m. delayed birth certificates

11. The Office of the Medical Examiner:

    a. administers the standards for the use of dead bodies or parts of bodies

    b. administers the Anatomical Gifts Act

    c. sets standards for the use of dead bodies for scientific study

    d. sets standards for the use of cremation

12. Emergency Medical Services

13. Solid and Hazardous Waste Management:

    a. planning

    b. transportation

    c. enforcement

    d. operation of facilities

14. Disease Control:

    a. reporting of incidence

    b. immunization

    c. detection

15. Medical Care Services

a. maternal and child health

b. administration of the Voluntary Formulary (generic drugs)

D. Objectives and Schedule of the Study

The following objectives were adopted by the Joint Subcommittee:

1. To ascertain whether the most cost-effective operation of the Office of Medical Assistance would be achieved by allowing this office to remain within the Department of Health, by shifting it to another department or establishing it as a separate agency.

2. To analyze the possible effects of relocation of the Office of Medical Assistance on the Department of Health's capability to provide services to Virginia's citizens, the number and quality of enrolled providers and the availability and effectiveness of services to recipients.

3. To analyze the scope and magnitude of the services provided by the Department of Health in order to ascertain whether the Department is fulfilling its proper role as a public health agency.

4. To evaluate the methods by which the Department of Health makes value judgments on programs and funding priorities.

5. To evaluate the Department's centralized role in directing the regional and local health departments to ascertain its appropriateness, efficiency and cost-effectiveness.

6. To evaluate the Commonwealth's policy in the public health area in order to ascertain the appropriate regulatory posture and authority of the Department and Board of Health.

It was proposed that the study progress from the most centralized functions of the Department to those services and programs which are delivered in the field at the regional and local levels. This progression had the advantage of providing the Subcommittee with a thorough and complete overview of the Department at the state level and leading naturally to examination of delivery of services at the regional and local levels. The Subcommittee examined the eight offices of the State Health Department in the first three meetings as follows:

July meeting: The Office of Medical Assistance

The Office of the Medical Examiner

The Office of Health Planning and

Resources Development

Rationale: These three offices perform centralized functions only. The flow of information and work is from the field to the state office. The programs administered by these offices do not have comparable local offices and delivery.

August meeting: The Office of Health Protection

and Environmental Management

The Office of Health Care Programs

Rationale: These two offices perform centralized policy-making functions and provide expert technical assistance to the field; therefore, their impact on local procedures and conditions is profound. The flow of information and work is primarily from the state office to the field.

October meeting: The Office of Management for

Community Health Services

The Office of Employee

Relations Management

The Office of Administration

and Staff Services

Rationale: These three offices are involved in the actual delivery as well as the administration of the services at the regional and local levels. The flow of information and work is between the regional and local levels, between the regional and the state levels and between the local and state levels. An understanding of the functions of these offices and how they interact with the other offices at the state level and the regional and local departments provided a sound basis for examination of the regional and local programs.

Other meetings: Study of regional/local

programs and continued analysis

of central offices.

Rationale: By this time, the Subcommittee had a good understanding of the various roles of the state department and began to examine its role at the local level in depth.

The Subcommittee began its study of the local programs with a large city having the demography and problems associated with delivery of services in an inner-city environment. The Subcommittee arranged for regional/local study by visiting the District Office in Lynchburg and the local department in Campbell County in order to understand the delivery of health services under different economic conditions.

E. Findings, Conclusions and Recommendations of the Joint Subcommittee

The scheduled survey and overview of the Department of Health was projected to require one year for the Joint Subcommittee to complete. Because the Department encompasses many programs and subprograms and review of some complicated and costly programs necessitated ongoing presentations at the various meetings, this work required an eighteen-month period. The Joint Subcommittee's findings and conclusions are summarized by office within the Department of Health and given in the order that the Subcommittee considered them.

I. Office of Medical Assistance

The Virginia Office of Medical Assistance provides services to approximately 400,000 clients, the majority of whom are categorically needy. Medicaid currently comprises over 8% of the entire state budget and over 80% of the Department of Health's budget.

In recent years, the Virginia Office of Medical Assistance has concentrated on developing an organization which eliminates redundancy and ensures proper use of available funding for the provision of quality and appropriate health services to Medicaid recipients in the most cost effective ways available. In order to accomplish these priorities, the Office of Medical Assistance has (1) revised its eligibility criteria and covered services; (2) implemented prospective rates for hospitals and nursing homes; (3) initiated personal care services as less costly alternatives to institutionalization; (4) implemented in-house utilization review as a less costly and more effective method of obtaining accurate utilization review; (5) broadened the preadmission screening program as a method of preventing inappropriate institutionalization; (6) aggressively sought third party reimbursement for rendered services; (7) upgraded the in-house auditing system to determine the propriety and reasonableness of reimbursable costs for all participating providers of services and to design reimbursement formulas; and (8) instituted a tough surveillance utilization review system to discover cases of fraud and abuse in the Virginia Medicaid program.

The Virginia Medicaid program has interagency contracts with the State Department of Social Services for determination of eligibility and the Department of Rehabilitative Services to provide disability determinations for eligibility and primary relationships with the other offices of the Health Department, particularly the local health clinics, and the Department of Mental Health and Mental Retardation.

Virginia is one of seven states having Medicaid programs which are administered within the state departments of health. The other states are California, Maryland, Tennessee, Wisconsin, Wyoming and the Virgin Islands. Most other states have programs administered within the state departments of social services. It appears that the Medicaid program is more appropriately administered by the state health departments than by the state departments of social services. The lack of medical knowledge and understanding of health care delivery systems among personnel in departments of social services makes it difficult for these departments to administer Medicaid cost-effectively or efficiently. In many Medicaid programs operated from departments of social services, the primary emphasis is on eligibility rather than on cost-effective delivery of quality services. There does not appear to be, however, any impediment to the operation of an effective and efficient Medicaid program as an independent department.

Conclusions:

The Joint Subcommittee believes that the efforts of the Office of Medical Assistance to improve its operation over the past several years have been commendable. The cost containment initiatives of this office have been models for other states to follow, notably, the preadmissions screening program, the personal care services program and the development of prospective rates for nursing homes and hospitals. The Joint Subcommittee believes that these efforts should be strengthened and extended and wishes to encourage the Office of Medical Assistance (1) to increase its efforts to contain costs while still providing the needy citizens of Virginia with a variety of quality services and (2) to reduce the need for institutionalization while developing viable alternatives.

During the 1984 Session of the General Assembly, the Governor proposed and the General Assembly approved Senate Bill Number 383, patroned by Senator Edward E. Willey, which will establish a new Department of Medical Assistance Services on March 1, 1985. This Subcommittee wishes to go on record as supporting this action.

The size and intricacy of the Medicaid Program have grown in recent years so that the budget for Medicaid alone is now larger than that of most other entire state agencies. In the opinion of this Subcommittee, because of the number and size of the programs included in the Department of Health, the economies of scale in management have reached the point of diminishing returns.

The Joint Subcommittee also feels that the size of the Medicaid Program, the political pressures exerted on it and the constant publicity it receives causes the energies and resources of the Department of Health to be concentrated on its operation. Therefore, separating the Medicaid Program from the Department of Health will provide the Commissioner and his staff with the opportunity to concentrate more effectively and single-mindedly on the delivery of the remaining programs, which are extensive. At the same time, the leadership of the new Department of Medical Assistance Services will be able to devote all of its attention to the efficient operation and innovative management of Medicaid.

Recommendations:

For the above stated reasons, the Joint Subcommittee recommends that:

1. The planning for the separation of the Medicaid Program from the Department of Health be carefully developed to take into consideration the relationships between Medicaid and the other programs of the central offices of the Department of Health and other state agencies;

2. The planning take into consideration the relationship of the local health departments with the Medicaid Program in order to ameliorate any adverse impact on the budgets of local governments; and

3. The new leadership for the Medicaid Program be chosen with a view towards appointing individuals familiar with the health care industry and its present changing status as well as the Medicaid Program as it operates in Virginia and in the Nation;

4. The Office of Medical Assistance continue to develop prospective reimbursement rates and fee-for-services limitations and to phase out cost-based reimbursement;

5. The Office of Medical Assistance continue to explore the full range of home-and-community-based waivers in order to decrease the need for and appropriateness of institutionalization; and

6. The Office of Medical Assistance continue to strive for cooperative, compatable and mutually beneficial relationships with other state agencies.

II. The Office of the Chief Medical Examiner

The Chief Medical Examiner must be a forensic pathologist by law in Virginia and licensed to practice medicine in the Commonwealth. He is assisted in his work by four assistant medical examiners based in regional offices located in the four corners of the State. These offices are: the Eastern Region Office in Norfolk, the Southwestern Region Office in Roanoke, the Northern Region Office in Fairfax and the Central Region Office in Richmond. The regional offices have an average staff of six people which represents an economical personnel level for accomplishing the sometimes heavy work load.

The primary functions of the Office of the Chief Medical Examiner are to provide prompt and competent medicolegal death investigations; to perform postmortem examinations; to provide medical examiner's evidence in court cases; to provide training in medicolegal aspects of death to law-enforcement personnel, medical schools and law schools; and to collect, process, and distribute anatomical material. Nearly 20% of all deaths in Virginia are investigated by the Office of the Chief Medical Examiner. All deaths by other than natural causes, whether accidental, suicide or suspected homicides, are investigated by this office. In addition to his primary duties, the Chief Medical Examiner must give approval for all cremations and burials at sea, if death occurred in Virginia. Further, crematoriums or cremators must be registered with the Department of Health.

Conclusions:

The Joint Subcommittee believes that the Office of the Chief Medical Examiner is well run with meager resources. The Subcommittee wishes to commend this Office for managing a sizeable volume of work with existing personnel.

The collection, distribution and processing of unclaimed bodies for the medical schools or other schools and colleges to use for educational purposes has become costly. The Joint Subcommittee believes that ways to reduce the cost to educational institutions for cadavers should be examined. Although the processing and distribution is accomplished by this Office with as low a cost as possible, the institutions complain that the cost of the cadavers is too high.

Further, there appear to be some duties which are less appropriate for this Office than others. Although approval for cremation of dead bodies appears a logical duty for the Office in order to protect the integrity of investigations, the registration of crematoriums or cremators with the Department of Health only adds to its responsibilities without contributing to its purposes.

Recommendations:

The Joint Subcommittee recommends that:

1. The registration of crematoriums and cremators be transferred from the Department of Health to the Board of Funeral Directors and Embalmers; and

2. The management of the collection, distribution and processing of unclaimed bodies be

evaluated to determine if the cost of this activity can be maintained at present levels or reduced; and

3. The staffing needs of the regional offices be evaluated in relationship to the work loads to ascertain the adequacy of the present personnel.

III. The Office of Health Planning and Resources Development

The Office of Health Planning and Resources Development subsumes six divisions with diverse functions as follows: the Division of Health Planning, the Division of Resources, the Division of Vital Records, the Division of Health Statistics and the Division of Medical and Nursing Facilities Services.

The Division of Health Planning is responsible for the planning, research and policy analysis required to develop the State Health Plan and staff the Statewide Health Coordinating Council. This Division also staffed the Perinatal Services Advisory Council which designed a comprehensive plan to deal with the high rate of perinatal death in Virginia.

The Division of Resources Development is one of the groups with the highest profile within the Health Department because this Division administers the regulatory program known as Certificate of Public Need. COPN comprises 85% of the Division's workload. This Division coordinates the COPN program with the licensure and certification functions of the Division of Medical and Nursing Facilities Services and the Virginia Medicaid Program. The staff support for the Statewide Health Coordinating Council's review of applications for COPN is provided by this Division. Up-dating of the State Medical Facilities Plan is conducted by the Division of Resources Development along with other activities related to the closing out of outstanding Hill-Burton construction loans and grants.

The Division of Emergency Medical Services is responsible for planning and developing a comprehensive coordinated statewide emergency medical services system, preparing the State Emergency Medical Services Plan, developing rules and regulations to govern emergency medical services, providing training and certification for pre-hospital emergency medical services personnel, administering the Virginia Rescue Squad Assistance Fund and the funds generated by the additional one dollar for motor vehicle registration approved by the General Assembly in 1983. Virginia now has computerized the EMS certification program, which is annually administered to over 30,000 volunteer personnel and approved regulations to govern emergency air evacuation units.

The Division of Vital Records registers all events of birth, death, fetal death, marriage, divorce, adoption, etc. which occur in the Commonwealth and arranges, indexes, preserves and certifies all such vital records. At the present time, only a small percentage of the records of the Division of Vital Records are computerized and the danger of deterioration of old records is great.

The Division of Health Statistics operates the vital statistics data system, the health facilities and health manpower data systems and the medical examiner statistical system. This Division maintains a comprehensive health information system and provides health data upon request as well as performing statistical consultation for other programs within the Department of Health such as Medicaid.

The Division of Medical and Nursing Facilities Services is charged with assuring that all Virginia health care facilities are in compliance with established federal and state standards. This Division makes on-site health care inspections for the purpose of licensing medical facilities and for the purpose of certifying medical facilities for Medicare and Medicaid payments. The certification functions are carried out in conjunction with the Division of Medical Social Services within the Office of Medical Assistance.

The Office of Health Planning and Resources Development is also responsible for implementing the geriatric assistants program, an eighty-hour practical course for certain nursing home employees. (This Office also included the Division of Data Processing at the time the Subcommittee reviewed it. The Division of Data Processing will be discussed under the Office of

Administration and Staff Services in which it is presently located.)

Conclusions

The Joint Subcommittee believes that Health Planning will become crucial in the near future as the Diagnosis Related Groups are implemented by the federal government and the impact of this implementation becomes more apparent. The Joint Subcommittee realized that the work of the Joint Subcommittee Studying the Feasibility of Maintaining a Regional Health Planning Mechanism in the Commonwealth would be a detailed study of health planning and regulation and did not, therefore, concentrate on this area. However, in the opinion of this Subcommittee the changing climate of the health care industry appears to require constant and careful evaluation of the regulatory stringency of the certificate of public need program. This program must be flexible enough to encourage those delivery systems which are most cost effective as well as provide disincentives for redundant capitalization.

The Joint Subcommittee wishes to commend the staff of the Division of Emergency Medical Services for their work in developing an excellent system in Virginia. The monumental task of training, administering and operating the EMS system in Virginia is accomplished with a largely volunteer force. None of the volunteers including the instructors, many of whom are medical professionals, are reimbursed for their expenses. The computerization of the EMS certification program will provide another mechanism for monitoring the quality of this volunteer force. The Joint Subcommittee also wishes to caution the Division to monitor the distribution and use of the new Emergency Medical Services funds carefully to ensure that the sudden influx of money does not in any way adversely affect the dedication and drive of the volunteers who implement this program.

The Joint Subcommittee wishes to encourage the Division of Vital Records to complete the automation of Virginia's vital records as quickly, efficiently and cost-effectively as possible. All available tools, for example, soft-ware packages, should be thoroughly examined before steps are taken to implement this important project. Virginia's Vital Records and Health Statistics were administered in one divison at the time this review took place. This Subcommittee viewed these functions as separate and did, therefore, introduce legislation to provide for two divisions. The Joint Subcommittee also felt that the preservation of Virginia's vital records was imperative and that the quality of Virginia's Vital Records Program, which has been a model for other states and other countries, must be maintained. Therefore, H.B. No. 570 and H.B. No. 571 were introduced and patroned by the Chairman, Frank M. Slayton, during the 1983 Session. These bills, which passed and are now law, conformed Virginia's Vital Statistics Law with the model act and established a fund for automation of these records, which sunsets on completion of this project (see Appendix A for copies of H.B. No. 570 and H.B. No. 571).

The Joint Subcommittee believes that the licensure and certification functions of the Division of Medical and Nursing Facilities Services are very important to the efficient operation of the Medicaid program and in assuring quality care to the citizens of the Commonwealth. The overlapping of the functions of this office and those of the Department of Social Services in licensing homes for adults and the Department of Mental Health and Mental Retardation in licensing Mental Health facilities appears to be a subject which bears detailed examination. Time limitations did not permit this Subcommittee to conduct this evaluation. However, the increasingly important role of homes for adults in long term care and the ever increasing medical services provided by these institutions makes the relationship of this division and the Social Services licensure program ripe for study. If the Commonwealth ever moves to provide Medicaid payments for placement in homes for adults, this issue will certainly become crucial.

Recommendations:

The Joint Subcommittee recommends that:

1. The Division of Health Planning and the Division of Resources Development carefully monitor the changes in the health care industry in order to adjust to these changes as may be necessary;

2. A study be conducted by the Health Department to ascertain whether any schedule for

reimbursement of expenses for Emergency Medical volunteer training personnel should be implemented;

3. The automation of the vital records be completed as quickly and as cost effectively as possible;

4. A future legislative study be conducted of licensure procedures for nursing homes and homes for adults and certification procedures for payment by Medicare and Medicaid to ascertain whether any consolidation of duties or changes in procedures would be appropriate.

IV. The Office of Health Protection and Environmental Management

The Office of Health Protection and Environmental Management is the largest group in scope of responsibilities within the State Health Department. This Office encompasses programs in epidemiology, health hazards control, water and solid and hazardous waste and plays a key role in protecting the public health through disease control and programs for occupational and environmental health.

The Division of Epidemiology includes a formal, routine surveillance system covering incidence of disease recorded in hospitals and laboratories and an informal surveillance system of reports of disease by newspapers and word of mouth. This program has helped to virtually eradicate from the Commonwealth such diseases as pertussis (whooping cough) and polio. School immunization requirements are enforced by this Division in cooperation with the public schools and local health clinics.

At the present time, the Bureau of Communicable Diseases in the Division of Epidemiology is working diligently to control the rabies epidemic. Loudoun County in Northern Virginia had the highest incidence of reported rabies in the country in 1981 (over 400 cases). This problem seems to be particularly intense among raccoons. The raccoon has adjusted to the urban environment by learning to forage for food in garbage and has increased in population in Northern Virginia and other densely populated areas. Experts do not know why the rabies epidemic has been localized among raccoons. They do know that some raccoons survive the disease. There is an intensive vaccination program underway in Virginia for domestic animals including cats because most local governments do not require immunization of cats, many cats are not immunized, wander freely and may contract the disease without the owners' knowledge.

At the time of this review, the Division of Epidemology also administered the Chronic Disease Unit which included the hypertension program, the cervical cancer program and the highly regarded Virginia Tumor Registry. These programs have been transferred to the Office of Health Care Programs.

The Division of Health Hazards Control includes branches which enforce statewide occupational health standards, inspect facilities as requested in order to assist companies in complying with occupational health standards and provide onsite consultation with employers in an effort to educate and train them in occupational health standards. This Division conducts an essentially regulatory program for employee and workplace health using the requirements set out by the federal law. Efforts are made to coordinate these activities with the regulatory and inspection activities of other state agencies. It should be noted some business officials have complained of redundant inspections. However, since the federal government withdrew its inspection program in Virginia and the inspection program is operated now entirely by the Commonwealth, these problems appear to have been alleviated. In fact the staffing level in this Division is relatively low; therefore, only about five percent of the more than 2000 state industries can be inspected in a year's time.

At the time of this review, the Division of Health Hazards Control also included such activities as the Toxic Substances Information Bureau, the Bureau of Radiological Health, Bureau of Tourist Establishment Sanitation, the Bureau of Environmental Health and the Bedding and Upholstery Furniture Inspection Program. All of these activities are focused on improving health or preventing health problems by controlling or monitoring environmental health factors.

The Bureau of Tourist Establishment Sanitation regulates overnight sleeping establishments,

restaurants, swimming facilities, service station restrooms and camp grounds. This Bureau has suffered severe budget reductions in the last several years. Therefore, the central office's duties in this area have been eliminated by transferring these functions to the Office of Management for Community Health Services and the delivery of these services completely to the field.

The Toxic Substances Information Bureau maintains a comprehensive inventory of chemicals used in or produced by industry in Virginia. This Bureau is not a regulatory agency but an information service and publishes "Health Hazard Alerts" on potential problems such as asbestos and urea formaldehyde. The Bureau of Toxic Substances Information provides toxicological assistance to other state agencies included on the Toxic Substances Advisory Council in order to prevent the need for duplication of this expertise in these other agencies.

The Bureau of Radiological Health handles the regulation of X-ray machines and monitors overall exposure to radiation in Virginia. The Bureau of Environmental Health handles sanitation matters such as sewage disposal, the milk sanitation program and the bedding and upholstery inspection program.

The Division of Water Programs works with the State Water Control Board to regulate the water quality in the Commonwealth and has sole responsibility as required by federal law for maintaining the quality of drinking water. This Division regulates sewage treatment systems using water standards which are virtually the same as the federal standards. This Division also subsumes the Bureau of Shellfish Sanitation, a program having as one of its primary duties the opening and closing of shellfish growing waters in Virginia and cooperating with neighboring states in regulating this activity.

There are a number of small communities in Virginia which do not have central water supplies or do have small, mostly non-public, water works. These communities have many problems and frequently look to the Division of Water Programs for help which it does not have the authority or resources to provide. Water resources and the problems of small, primarily non-public water works appear to be subjects which bear careful watching and possible state action.

Because the control of water supply impacts one of humanity's most basic concerns and causes many emotional reactions, this Division's work generates a number of complaints. This division is involved in every crisis related to the drinking water supply of the communities in Virginia. Many individuals continue to feel that surface water on their property should not be a matter of state concern, yet the same individuals frequently believe that the state should take complete responsibility for cleaning up any contamination. Wastewater can easily contaminate the surface and ground water and even in costly industrial treatment systems, wastewater is still not very clean. Therefore, the work of this Division is sensitive and difficult in a society which is relatively densely populated and still retains many of the ideas about property cherished by our forebearers.

The Division of Solid and Hazardous Waste permits hazardous waste and solid waste disposal, treatment, storage and transportation, regulates solid and hazardous waste management activities such as the financial responsibility regulations and is presently studying the feasibility of establishing a low level nuclear waste disposal facility in Virginia. It should be noted that Virginia has more than two hundred waste sites potentially in need of clean-up, only four of which qualify for "Superfund" money. Superfund grants must be matched by ten percent by the state qualifying for the funds.

Conclusions:

Because of the interaction between the programs in the Office of Health Protection and Environmental Management, industry and the private citizen, the activities of this office generate some controversy. In recent years, the revision of the Sewage Disposal and Water Handling regulations has been the source of many complaints and the reason for the introduction of a number of pieces of legislation. Since the initiation of this study, some of the administrative functions related to the permitting of sewage disposal systems have been realigned by the Department of Health and many of the problems have been resolved. There still remains, however, much misunderstanding of the new regulations and some bad feelings on the part of developers and builders. These issues appear to be less intense because of the elimination of

some backlogs of applications for permits and a growing understanding of the new regulations and the need for them.

The personnel of this Office pursue their duties with vigor and a real desire to protect the citizens of Virginia from encountering health problems. This very quality is laudable and, at the same time, occassionally creates conflict. The Joint Subcommittee feels that regulatory activities of the Department of Health provide a necessary check and have served to prevent the Commonwealth from experiencing many of the environmental difficulties faced by other states. The Subcommittee wishes to caution the administrators of regulatory activities which impact localities, consumers and industry to maintain flexibility and to strive for good public relations in order to alleviate misunderstandings and complaints.

The functions of the Office of Health Protection and Environmental Management interface with the duties of several other state agencies. Although the technical knowledge necessary to administer the programs within this Office must include medical expertise and a health perspective, there must be close cooperation, coordination and interaction between this Office and other agencies. In past years, there was a need to improve these relationships, but a concerted effort has been made recently to develop a close, compatible and complimentary atmosphere. The Joint Subcommittee wishes to recognize the great progress in the development of harmonious and participatory relationships between this Office and other state agencies as evidenced by the promulgation of joint regulations and the many interagency projects. In the view of the Joint Subcommittee, close working relationships and cooperative ventures supersede in importance the location of the programs within the structure of state government.

Recommendations:

The Joint Subcommittee recommends that:

1. When adding responsibilities or new programs to those of the Office of Health Protection and Environmental Management, the General Assembly consider the needs for additional resources;

2. A study be made by a future legislative subcommittee of mechanisms for funding the ten percent match required by the federal government for Superfund grants;

3. A study be conducted by a future legislative subcommittee of ways to fund the replacement or upgrading of inadequate or decaying water works, whether publicly or privately-owned, which will include the feasibility and means of encouraging regionalization of water supply systems; and

4. The Office of Health Protection and Environmental Management continue to work with other relevant state agencies to coordinate interfacing programs in every possible way including, but not limited to, inspections, information, expertise and the handling of crises.

V. Office of Health Care Programs

The Office of Health Care Programs provides the technical leadership for the medical, nutritional, dental and hospital services delivered by and through the local health departments. This Office serves as consultant and advisor for the field delivery of public health care and monitors the appropriateness of current public health services.

The Division of Family Health Services encompasses programs for maternal and child health, family planning, crippled children, medical social work and public health nutrition. This is one of the largest divisions in terms of numbers of personnel within the Department. This program receives substantial sums of federal money. At the time of this review, the Maternal and Child Health Block Grant totaled $7,086,400.

The Bureau of Maternal and Child Health provides the standards for the delivery of quality maternal and child health services to primarily those mothers and children from low income families. It must be noted that Virginia ranks 38th in state infant mortality rates and that efforts are presently being made to alleviate this situation. The Maternal and Child Health program is

responsible for implementing the plan to reduce this rate which was developed by the Perinatal Advisory Council.

The Bureau of Family Planning provides family planning services through federal funding, which is supplemented by the Department of Social Services. It should be understood that the work of this Bureau must be carefully coordinated with the work of the Bureau of Maternal and Child Health in order to assist mothers at high risk of having low birth weight babies or babies with developmental disabilities.

The Bureau of Public Health Nutrition relies heavily on the federal Women, Infants and Children program for its funding and services. WIC, a 100% federally funded program, is now responsible for educating approximately 58,000 people in Virginia about nutrition and for supplementing diets lacking in needed nutrients. This program is focused on bringing about positive change in statewide eating habits and is considered a cost effective and efficient program. The WIC program operated in Virginia on a budget of approximately $21.9 million in 1982 and generated over $700,000 in state sales tax.

The Bureau of Crippled Children is charged with assuring the availability of care for children with physically crippling conditions or potentially crippling conditions which require specialized treatment for correction or rehabilitation. This program has in recent years experienced fluctuations in federal funding.

The Bureau of Medical Social Work consults and assists the local and district health departments, establishes standards for all medical social workers employed within these departments and monitors the activities of these medical social workers.

At the time of this review, the Division of Public Health Nursing was included in the Office of Health Care Programs. This Division has since been transferred to the Office of Management for Community Health Services.

The Division of Public Health Nursing establishes standards for public health nursing within the Department of Health, provides technical assistance to the local health departments, schools of nursing and professional organizations, administers the statewide nursing scholoarship program, develops procedural manuals, protocols and manpower guidelines for public health nursing in Virginia and coordinates the public health nursing clinical experience for nursing students in certain local health departments. This Division also administers the home health services program in coordination with the Office of Management for Community Health Services and maintains a cost reporting system of earned revenues derived from Medicare, Medicaid and other third party payors for these home health services. The coordination and integration of health department services for long-term care to the ambulatory elderly and disabled also fall within this Division. As already noted in Section IV., the Bureau of Chronic Disease Control is now situated within this Office and has the responsibility for administering the cervical cancer program, the hypertension program and the Virginia Tumor Registry.

The Division of Dental Health develops the standards, policies and procedures for the operation of the public health dental programs in the local health departments, promotes the appropriate use of flouride and other preventive measures and administers the dental hygiene scholarship program. In some areas of the state, there appears to be great need for dental services, e.g., Bedford County, whereas in other areas, there is a surplus of dentists. This program attempts to resolve these problems by allowing the recipients of the scholarships to serve in areas of need rather than paying the money back.

Conclusions:

The Joint Subcommittee wishes to stress that every effort should be made to remediate the high infant mortality rate in the Commonwealth. Virginia has always had a tradition of excellence in its state programs which does not appear to admit the continuation of this situation. Further, it is the belief of the Joint Subcommittee that intense efforts to educate and serve women at high risk would benefit the women and the babies and the Commonwealth by reducing the need for expensive neonatal care. The Joint Subcommittee noted in an evaluation of the budget priorities for the Maternal and Child Health Care program that larger sums were allocated for remediation than for prevention. Whereas this budgeting is understandable, the area

of prevention appears to be underfunded and underutilized. The Joint Subcommittee has also noticed that the planning districts with the highest low birth weight rates have remained the same since 1975. These same areas of the state are the ones with the highest incidences of infant mortality.

It is the belief of the Joint Subcommitte that concentrated outreach programs should be developed in order to alleviate this problem in coordination with the health care delivery programs already in place. The efforts to provide family planning services should be, in the view of the Joint Subcommitte, interfaced with the outreach programs in order to educate these same women and, perhaps, prevent unwanted births. Since so many of the programs within the Office of Health Care Programs focus on the families of the very women who must be reached, the Joint Subcommittee feels certain that a task force approach to this problem would be effective if it focused on every aspect of prevention such as nutrition, prenatal care, family planning services, neonatal care, medical social services and public health nursing. For example, even the Division of Dental Health could, in the opinion of the Joint Subcommittee, join in these efforts by offering education in the other services available to its clients.

The Joint Subcommittee believes that in this time of strained resources and increased need for services it is essential that innovative and inspired leadership be provided for the vital services in this Office.

Recommendations:

The Joint Subcommittee recommends that:

1. The efforts to reduce infant mortality in Virginia be reassessed and revised to focus more heavily on prevention rather than remediation;

2. The Office of Health Care Programs establish a timetable for the systematic reduction in infant mortality in the Commonwealth and work to achieve this goal; and

3. Outreach programs be developed using a multidisciplinary approach in order to establish a viable, coordinated effort to educate people about the need for prenatal care, family planning, proper nutrition and dental hygiene.

VI. Office of Management for Community Health Services

The Office of Management for Community Health Services provides the field operations supervision as it relates to administrative policies, resource management and the development of standards and programs for the regional, district and local health departments. In other words, this Office serves as the Commissioner's principal supervisory assistant through the network of the regional offices for the operations of the community based public health departments.

The regional network consists of five offices. The Northwest Region includes the health districts for Central Shenandoah, Lord Fairfax, Rappahannock Area, Rappahannock-Rapidan and Thomas Jefferson. The Northern Region includes the health districts for Alexandria, Arlington, Fairfax, Loudoun and Prince William. The Southwest Region includes the health districts for Alleghany, Central Virginia, Cumberland Plateau, West Piedmont, Lenowisco, Mount Rogers, New River, Pittsylvania-Danville and Roanoke City. The Central Region includes the health districts for Charles City-Hanover, Chesterfield, Crater, Henrico, Piedmont, Richmond City and Southside. The Eastern Region includes the Health Districts for Cheasapeake, Eastern Shore, Hampton, Middle Peninsula, Norfolk, Northern Neck, Peninsula, Tidewater and Virginia Beach. The Regional health Directors and the District Health Directors must be physicians and employed full-time.

The Office of Management for Community Health Services, although carrying heavy responsibilities, includes few personnel at the state level. At the time of this review, this Office employed three professionals and three support personnel. This level has been increased with the transfer to this Office of several programs, for example, the Division for Public Health Nursing and the Bureau of Tourist Establishment Sanitation. The personnel level in the regional offices ranges from five to eleven. Approximately 2,746 people are employed full time by the

district and local health departments, including physicians, nurses, sanitarians and others. More than 500 people are employed by these departments on an hourly basis.

In many cases, the authorized employment levels do not provide the manpower to meet the demand for public health services and the support of the local medical community must be solicited. During the fiscal year 1981-1982, private physicians provided 34,350 hours of professional time and 228 home health contract personnel were used. In addition to these hourly personnel, the Women, Infants and Children Program employs approximately 69 full-time and 169 hourly employees. The Division of Family Planning employs approximately 214 full-time and 33 hourly employees and approximately 30 more full-time and 60 hourly employees are employed with federal funds. All of these employees are officially state employees.

The funding for district operations is appropriated under the Community Health Services Program from the State. Matching funds must be appropriated by local governments according to the percentage required by the formula for the state/local cooperative budgets. Fees collected from third party payors or recipients of services and allocations from block and categorical grants also are included in the budgets as add-ons.

Because of the need for local approval, the district budgets are prepared annually. The budgeting process is begun with the obtaining of the adjusted appropriated figures from the agency fiscal office. The regional office is provided the figures and budget guidance in October. Each regional office makes allocations to the districts within its region and the district offices develop budgets for each of their local health departments. After local approval has been obtained, the district office consolidates the local budgets into a single district budget and forwards this document to the central office. Each district must obtain written commitments from each local governing body for the appropriate matching funds. Cumulative totals must be within the allocation for each region and commitment statements must be received from all localities before final approval is given for budgets. The local shares of the cooperative budget are paid to the State in quarterly installments. At the end of the fiscal year, final settlements are prepared and overpayments, if they exist, are returned to the local government along with any local share of excess revenues.

The local clinics charge fees for health care services on a sliding schedule based on the patient's income. The patient may receive free services or may be required to pay 1/3, 2/3 or 100% of the fee established. This eligibility/fee system has been coordinated in the last several years with the Medical College of Virginia and the Medical College at the University of Virginia.

The formula for the state/local cooperative budget was originally developed in the 1950's. An arbitrary standard of local contribution of not less than 20% or more than 45% was established at that time. The formula hinges on the estimated true value of real property and public service corporations as determined by the State Department of Taxation. In 1964, this formula was reviewed by a legislative committee and the present minimum contribution of 18% was established as recommended by this group. The formula is reworked every two years consistent with the biennium budget cycle for each locality. The lowest Estimated True Value of real property and public service corporations is also established every two years. At the time of this review, Clifton Forge was the lowest with an ETV of $66,626,000 (see Appendix B for an explanation of the formula).

Any locality wishing to exceed the requirements of the state may do so by providing 100% of the funds for the desired supplemental services. At the time of this review, four localities were funding such additional services or positions.

Each of the regional offices faces certain unique problems. The Northern Region Office has two major concerns - the control of the rabies epidemic and the need for services to the increased refugee populations. The Southwestern Region Office is concerned with the lack of sewage disposal systems in unincorporated towns and the discharge of raw septage into streams in Lee, Scott, Wise, Bland, Tazewell, Smith, Buchanan, Dickinson and Russell Counties. The Central Region Office is concerned primarily with fiscal matters because of the inability of some localities to match even the modest amounts required under the formula in this area. The Eastern Region is concerned with the control of venereal disease, particularly gonorrhea. The Northwestern Region faces problems in the areas of sewage disposal, control of the rabies epidemic and the increase demand for family planning, pediatric and maternity services because

of the present economic conditions.

The duties of the regional offices include the review of the district budgets for consistency, local match, dollar limitations, calculations, proper format, and requests for additional personnel as well as revenue and cost report review. These offices also utilize a management-by-objectives approach to promote efficiency. The regional offices evaluate the district administrators at least once every three years and conduct medical quality reviews at least yearly. All personnel actions are routed through these offices. These offices also monitor all procedural and policy changes and report to the central office on any logistical problems. It should also be noted that the Women, Infants and Children Program is administered through the regional offices. In summary, these offices provide coordination, exchange of information, quality control, eliminate duplication and oversee the fiscal matters for all field operations.

The district offices are charged with coordinating community resources and facilitating the delivery of community public health programs. These offices administer areas with widely different demographies and monitor the delivery of services to patients with diverse needs.

Conclusions:

The Joint Subcommittee commented on the improvement in the community public health programs brought about by the establishment of the regional offices. These offices have served as the first line for resolution of problems in the field delivery of services. It must be noted, however, that the cost to the state for maintaining these mid-level management offices has increased and with meager financial resources being stretched, there is a need to evaluate the role of the regional offices as well as the level and qualifications of their personnel.

The Subcommittee also wishes to note the many comments from administrators in the field offices about the need for additional financial assistance from the state and the possiblity of fiscal crises in the local areas in the future. The Joint Subcommitte has reviewed several alternatives for revising the state/local cooperative budget formula. All of thse alternatives appear to require greater expenditures of state funds than are presently available. The formula has been described as inequitable and insufficient and in dire need of revision. The local governments are said to be struggling in many parts of the state to fund their matches and are not apparently in a position to provide substantial additional sums in most cases. The Joint Subcommittee agrees with all of these statements and wishes to state its sincere wish that this study could have resulted in a revision of the formula. However, at this time, the alternatives presented to the Subcommittee are not fundable. The Joint Subcommittee feels that the formula must be upgraded or revised as soon as fiscally possible.

The inspection of all overnight sleeping establishments, restaurants, swimming facilities, service station restrooms and camp grounds and the approval of septic tank permits are conducted by the district and local health department sanitarians. While some of the required inspections appear to be necessary to protect the public health, the inspection of service station restrooms does not in the opinion of the Joint Subcommittee. The time and energies of the sanitarians are already overtaxed, therefore, the inspections of service station restrooms are cursory and infrequent. Service stations must be sensitive to public demands and are subject to inspections by agents of their franchising organizations. These pressures appear to the Joint Subcommittee to be more effective than the state mandated inspections. For these reasons, the Joint Subcommittee believes the statutory requirement for inspections of service station restrooms should be eliminated.

The need for controlling the rabies epidemic has been noted in several places in this report. The Joint Subcommittee hopes that local health officials will impress on local governments the need for strict enforcement of immunization requirements for domestic animals and the need for ordinances requiring cats to be immunized.

It was the feeling of the Joint Subcommittee that the local governments in areas of the state in which sewage disposal is a problem should take the responsibility and initiative for resolving these problems. There may be a need, however, to examine the means for establishing sanitary districts and the funding of systems in low income areas.

Recommendations:

The Joint Subcommittee recommends that:

1. An administrative study be conducted of the operations and funding of the regional offices including the qualifications required of the directors in order to ascertain whether these offices are vital to the operation of the health department, the directors should be required to hold medical degrees and if the expense of these operations can be held in check;

2. The State/local Cooperative Budget Formula be studied and revised to provide a more realistic state share within the present fiscal constraints;

3. Pending the availability of resources to make a significant change in the method of funding local health departments, the Department of Health is encouraged to seek ways for allowing the ceiling on the cooperative budget to be adjusted to provide some relief from the increasing costs of public health services imposed on local governments in low income areas;

4. Section 32.1-200 of the Code of Virginia be amended to eliminate the regulation of service station restrooms; and

5. The personnel of the regional, district and local health offices strive to promote good relationships with local governments while still providing these local governments with guidance, information and quality services.

VII. The Office of Administration and Staff Services

The Office of Administration and Staff Services administers the procurement services for the entire Department of Health, coordinates the development of the biennium budget request, provides data processing services, reviews and approves all federal grants and contracts and all other contractual agreements, develops and implements health education programs and public information services and conducts inservice training and orientation programs for the staff of the Health Department.

This Office subsumes the Division of Health Education and Information, the Division of Purchasing and General Services, the Division of Accounting and Budgeting Services, the Division of Staff Delelopment, the Division of Internal Audit and the Division of Data Processing.

The Division of Health Education and Information establishes standards of practice for health educators and information officers employed within the State Health Department, coordinates and evaluates health education and information programs, administers the Health Education-Risk Reduction and Rape Prevention and Treatment Programs as part of the Preventive Health and Health Services Block Grant, staffs the Statewide Health Education Advisory Committee and plans and implements health education programs. The time of this review, this division was located within this office, but has since been transferred to the office of Health Care Programs.

The Division of Purchasing and General Services procures supplies, equipment, insurance coverage, shipping services and materials for all elements of the Health Department, provides pharmacy services to clinical programs, manages the permanently assigned state vehicle fleet, renders technical assistance to district and local health departments for real property leases, and assists in the negotiation, preparation and administration of contracts.

The Division of Accounting and Budgeting Services assists Department personnel in the preparation of the biennium budget, compiles the biennium budget, prepares budget analyses, provides financial control over agency expenditures, handles all revenue collections, and processes all accounts payable, disbursements and the department payroll.

The Division of Staff Development plans and administers all inservice education programs within the Department of Health by rendering technical assistance and providing equipment and instructors to the local health departments, formulating needs assessments and organization recommendations and conducting employee training programs. Since this review, this Division has been transferred to the Office of Management for Community Health Services.

The Division of Internal Audit reviews the reliability and integrity of financial information, evaluates the effectiveness of the Department's internal accounting and operating control systems, and assesses the operating performance of the elements of the Department in order to ascertain the economy and efficiency of resource use. This Division has been moved to the Commissioner's Office.

The Division of Data Processing provides information processing, storage and data retrieval services for the administration of the Department, patient management and program evaluation. This Division primarily maintains terminals connected to a central state computer bank. The Department personnel complain that the cost of services provided by the state system is prohibitive. The Division of Data Processing has been working with other elements of the Department to bring about the automation of budgeting, record keeping and reporting activities and thereby, provide for more timely, relevant data.

Conclusion:

The Joint Subcommittee wishes to state that, in its view, every possible effort should be made by this office to monitor the funds expended by the Department of Health and ensure that hard-headed practicality governs the budgeting within the Department. Bearing in mind the variety of services and programs offered by the Department of Health and the centralized administration of public health services in Virginia, this office is faced with heavy responsibilties. The Joint Subcommittee wishes to recognize the enormity of the tasks undertaken by the Office of Administration and Staff Services. It is the belief of the Subcommittee that the leadership in this office must be tenacious in their efforts to understand the workings of the various programs in the Department and dedicated to the principle of safeguarding the Commonwealth's financial integrity.

The cost of using the central computer banks is a matter of concern to the Joint Subcommittee. The Joint Subcommittee understands that the initial purchase by the state of mainframe computers in the belief that such purchases would be cost effective may not have been as wise as the General Assembly believed. The development of mini and macrocomputers has reduced the cost of data processing and advanced the state of technology considerably. The Joint Subcommittee feels that an indepth analysis of the cost and operations to the Health Department of data processing would be timely, however, this study committee did not have time for this evaluation. Further, the Joint Subcommittee believes the automation of information at the district and local levels will provide valuable budgeting and operating data.

Recommendations:

The Joint Subcommittee recommends that:

1. Continued study be conducted of the cost control and budgeting systems within the Department in order to ensure the most effective and efficient use of the Commonwealth's resources; and

2. A study of the cost of data processing to the Department of Health be conducted in order to ascertain ways for reducing this cost and increasing its efficiency.

VIII. The Office of Employee Relations Management

The Office of Employee Relations Management administers the personnel management system of the Department of Health including classification, compensation management, equal employment opportunity, preparation of personnel policies, grievance resolution and recruitment, hiring and reduction-in-force policy. This Office encompasses the Division of Classification/Compensation, the Division of Equal Employment Opportunity, the Division of Personnel Practices and the Division of Employment Services.

The Division of Classification/Compensation Management performs job analyses, evaluation of position reallocations and establishment, determines qualification standards for staff positions and administers starting pay policy. It should be noted that the many positions held by physicians within the Department are always classified at higher pay rates than positions held by other

professionals. This is true even for the assistant commissioners, who are not all classified at the same level, although the work in each office is comparable.

The Division of Equal Employment Opportunity prepares and administers the Department's affirmative action plan, assures compliance with federal Equal Employment Regulations and other federal law (such as Sections 503 and 504 of the Rehabilitation Act of 1973) and provides pre-grievance counseling and assistance.

The Division of Personnel Practices maintains all of the personnel records for Department employees, prepares and disseminates Department personnel policies, assists Department officials in the interpretation of personnel policies and in the administration of the state lay-off policy.

The Division of Employment Services recruits applicants and hires personnel for vacant positions within the Department, compiles employment statistics and provides career counseling and outplacement services to employees of the Department.

It should be noted that all of these services are provided from the central office to the entire health department, whether central, regional, district or local, and impact every one of the approximately 4000 employees scattered throughout the state.

Conclusions:

The Joint Subcommittee believes that job qualifications including degrees are important criteria for establishing pay rates. However, it is the feeling of the Joint Subcommittee that many administrative positions and functions within the Helath Department do not require a medical degree. Further, the Joint Subcommittee understands that work performance and experience may be more important than degrees. Therefore, the Joint Subcommittee does not believe that there is need for as many advanced degrees for administrative personnel as presently required by the Department of Health. In addition, the Joint Subcommittee wishes to state that an evaluation of the classification and pay rates of personnel performing comparable work appears to be in order.

The Joint Subcommittee understands the difficulty encountered within this Office in administering the personnel policies of the Commonwealth to such a diverse group dispersed over the state, all of whom are state employees. The size of the group and the geographical distances make the implementation of such policies as the grievance procedure and its timelines particularly hard. The Joint Subcommittee recognizes the great effort that must be made to comply with the state standards by this office.

Recommendations:

The Joint Subcommittee recommends that:

1. A study be conducted of the job classifications and compensation within the Department of Health to assure that pay rates and classifications are equitable and consistent;

2. The personnel needs of the Department of Health be reassessed as they relate to the responsibilities of the positions; and

3. In the event a study of the state grievance procedure is conducted by the legislature during the 1984 interim, the leadership of the Office of Employee Relations Management participate fully.

F. Summary Statement

In conducting this two year study, the Joint Subcommittee has learned a great deal about the operations and structure of the Department of Health. There is no doubt in the minds of the members of this Subcommittee that among the personnel of the State Department of Health there are many dedicated, conscientious and capable people. A review of the functions of each central office and the field trip to visit the District Office at Lynchburg and the local office in Campbell County have impressed the Joint Subcommittee with the diversity of the responsibilities

of the Department of Health and the magnitude of the coordination required to deliver its services. Therefore, the Joint Subcommittee feels strongly that all personnel within the Department at every level must strive to achieve direct and clear communications between the various offices and to cooperate fully in the planning and delivery of services. The two year period in which this study was conducted was insufficient to mount a detailed examination of the operations of the Department. However, the Joint Subcommittee believes that it has identified specific areas of need and issues for study that will provide the Department with future guidance and eventually result in valuable benefits to the Commonwealth and its citizens as well as the Department.

The Joint Subcommittee wishes to thank the many employees of the Department of Health who participated in this study for their cooperation,, courtesy, ideas and comments.

Respectfully submitted,

Franklin M. Slayton, Chairman

Adelard L. Brault, Vice-Chairman

Joseph P. Crouch

Jay W. DeBoer

Thomas J. Michie, Jr.

Alson H. Smith, Jr.

Warren G. Stambaugh

Edward E. Willey

DISSENTING-IN-PART OPINION OF ADELARD L. BRAULT

Although I agree with and approve the majority of this report, I cannot join with the rest of the Joint Subcommittee on the conclusions and recommendations related to the separation of the Office of Medical Assistance from the Department of Health. The rationale for Senate Bill Number 383 is, in my opinion, weak and unsubstantiated. The Virginia Medicaid Program has come a long way in the last several years. As noted in this report, it is considered in many respects to be a model for other states to follow. Virginia has been lucky to have dedicated, knowledgeable people working in this program. The effects of the action to remove Medicaid from the Department of Health on the momentum of the program and the morale of its personnel could be profound.

The establishment of a separate Department of Medical Assistance Services has not been the subject of this study or any study conducted by the General Assembly or, to my knowledge, any study conducted by an executive group. In my opinion, support of such an action in this report goes beyond the purview of this study.

The Medicaid Program has many primary and secondary relationships, both formal and informal, with other programs within the Department of Health and within other state agencies. The effects of creating a new department on these relationships have not been evaluated, and no preplanning for their reorganization appears to have taken place. An action as serious as establishing a new department should have been examined to ascertain the financial, administrative and health care delivery advantages and disadvantages. In my opinion, these factors should have been weighed and decisions made about including specifications in the law before any recommendation was made or action taken.

Creating a new department will require the establishment of new support services such as personnel, administration and, of course, fiscal. This expertise is presently provided to the Medicaid Program by the central offices within the Department of Health. The Department of Health has the expertise to deal with the health care industry and providers. Presumably, this expertise will have to be duplicated in the new department. If the duplication of this expertise is not anticipated, then the purposes and goals of the Medicaid Program in Virginia will become drastically altered. Medicaid will no longer be a program to deliver quality health care services cost effectively to needy citizens. Medicaid could become just another insurance provider–like Medicare–without a caring philosophy or the cost-containment initiatives of the present program.

In my view, all of the provisions of Senate Bill Number 383 should have been the subject of legislative study. For example, the legislation does not provide for the manner or amount of compensation for the new board. The new board will consist of five unspecified health care providers and six citizens who are not health care providers. In contrast to this non-specific membership, the Board of Health is composed of nine members, six of whom are individual health care providers–two physicians, one dentist, one pharmacist, one nurse and one veterinarian. The General Assembly has strenuously resisted the efforts to place institutional and allied health care providers on the Board of Health. The lack of specificity for the membership of the new board appears to me to have the potential for creating intense political pressure on the Governor and the new department. If the idea behind the new board and department is to provide the program with more effective, "single-minded" leadership, the membership of this board should have been more carefully thought out, in my opinion. Further, given the importance and expense of creating a new department, the legislation should have provided the new board and department with policy guidance.

Because I do not believe that merely altering organizational structure promotes the development of effective or efficient programs, and for the above-stated reasons, I cannot support the separation of the Office of Medical Assistance from the Department of Health.

I would hope the General Assembly will provide for a careful and deliberate legislative study of the effect of this change in the 1985 session with the view of taking any appropriate corrective action in the 1986 session of the General Assembly.

APPENDIX A

REPR

HOUSE JOINT RESOLUTION NO. 11

Requesting that a joint subcommittee study the operation and services of the Department of Health.

Agreed to by the House of Delegates, February 20, 1982
Agreed to by the Senate, February 26, 1982

WHEREAS, total expenditures for health care services in Virginia and nationwide have increased dramatically in recent years, while reports of fraud and abuse associated with public health programs have undermined public confidence in the administration of health care programs and services; and

WHEREAS, the expansion of services to prevent disease and to promote good health over the past decade has included the creation of programs which combine health and social services as well as the development of programs to improve the environment and to prevent hazardous situations that endanger public health; and

WHEREAS, the development of public health programs and services has been accompanied by the promulgation of rules and regulations to govern practices of governmental entities, medical professions, business, industry and private individuals; and

WHEREAS, citizens have expressed grave concern over what they perceive to be excessive and unnecessary governmental regulation of medical and environmental practices throughout the Commonwealth; and

WHEREAS, in 1978, the Joint Legislative Audit and Review Commission issued a series of reports focusing on medical assistance programs in Virginia, yet the Department of Health is responsible for many health programs including environmental health, occupational health and special health services which were not subject to that review; and

WHEREAS, during the past three years the Department of Health has been forced to deal with initiatives in medical and environmental health care as well as with diminishing federal and state funds to meet the demand for health care services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee study the operation of the Department of Health and study the health care services administered by the Department of Health. The joint subcommittee shall review all services administered and regulated by the Department and shall consider whether such services are appropriately administered and regulated.

The joint subcommittee shall be composed of eight members. Five members shall be appointed by the Speaker of the House of Delegates: three members from the Committee on Health, Welfare and Institutions and two from the Committee on Appropriations.

Three members shall be appointed by the Senate Privileges and Elections Committee: two from the Committee on Education and Health and one member from the Finance Committee.

The joint subcommittee shall submit any recommendations it deems appropriate to the 1983 and 1984 Sessions of the General Assembly.

The cost of this study shall not exceed $13,000.

1983 SESSION

CHAPTER 235

An Act to amend the Code of Virginia by adding a section numbered 32.1-273.1, establishing the Virginia Vital Statistics Automation Fund.

[H 570]

Approved MAR 16 1983

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-273.1 as follows:

§ 32.1-273.1. Virginia Vital Statistics Automation Fund.—For the purpose of fully automating the system of vital records provided for in this chapter, there is hereby established the Virginia Vital Statistics Automation Fund.

Two dollars of each fee collected by the State Registrar shall be deposited by the Comptroller to this fund to be appropriated for this purpose to the Department of Health by the General Assembly as it deems necessary.

Deposits to this fund shall cease at such time as the system of vital records for Virginia has become fully automated and the fund shall expire. Any funds unexpended at expiration shall revert to the general fund.

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President of the Senate

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Speaker of the House of Delegates

Approved:

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Governor

1983 SESSION

CHAPTER 240

An Act to amend and reenact §§ 32.1-249 through 32.1-252, 32.1-256 through 32.1-264, 32.1-269 through 32.1-274 and 32.1-276; to amend the Code of Virginia by adding a section numbered 32.1-275.1 and by adding in Title 32.1 a chapter numbered 7.1, consisting of a section numbered 32.1-276.1, and to repeal § 14.1-91 of the Code of Virginia, relating to vital records and health statistics; penalty.

[H 571]

Approved MAR 16 1983

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-249 through 32.1-252, 32.1-256 through 32.1-264, 32.1-269 through 32.1-274 and 32.1-276 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 32.1-275.1 and by adding in Title 32.1 a chapter numbered 7.1, consisting of a section numbered 32.1-276.1, as follows:

§ 32.1-249. Definitions.—As used in this chapter:

1. "Dead body" means a ~~lifeless~~ human body or *such* parts of such *human* body ~~or bones thereof~~ from the ~~state~~ *condition* of which it reasonably may be concluded that death recently occurred.

2. "Fetal death" means ~~the death caused by induced abortion or the~~ death prior to the complete expulsion or extraction from ~~the~~ *its* mother of a product of human conception, ~~irrespective~~ *regardless* of the duration of pregnancy ~~,~~ *;* death ~~being~~ *is* indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

a. "Induced termination of pregnancy" means the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus and which does not result in a live birth.

b. "Spontaneous fetal death" means the expulsion or extraction of a product of human conception resulting in other than a live birth and which is not an induced termination of pregnancy.

3. ~~"Filing"~~ *"File"* means the presentation of a ~~certificate, report or other~~ *vital* record provided for in this chapter ~~, of a birth, death, fetal death, adoption, marriage or divorce~~ for registration by the Department.

4. "Final disposition" means the burial, interment, cremation , *removal from the State* or other *authorized* disposition of a dead body or fetus.

5. ~~"Health statistics" means public health and medical data derived from vital records and other related records and reports.~~

6. "Institution" ~~means~~ any establishment, public or private, which provides inpatient medical, surgical, or diagnostic care or treatment, or nursing, custodial or domiciliary care ~~to two or more unrelated individuals~~ , or to which persons are committed by law.

7. "Live birth" ~~means the~~ complete expulsion or extraction from ~~the~~ *its* mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

8. "Physician" means a person authorized or licensed to practice medicine or osteopathy in this Commonwealth.

9. "Registration" means the acceptance by the Department and the incorporation ~~in its official records of certificates, reports, or other records of births, deaths, fetal deaths, adoptions, marriages, or divorces~~ *of vital records* as provided for in this chapter *into its official records* .

10. ~~"State Registrar" means the State Registrar of Vital Records and Health Statistics.~~

11. "System of vital records ~~and health statistics~~ " means ~~a system for the~~ registration, collection, preservation, amendment, ~~and~~ certification of vital records *;* ~~and other health related records and reports and the tabulation, analysis, and publication of statistical data~~ *the collection of other reports required by this chapter; and related activities* .

12. "Vital records" means certificates *,* *or* reports ~~and other records~~ of births, deaths, fetal deaths, adoptions, marriages , ~~and~~ divorces ~~and amendments~~ *or annulments and amendment data related* thereto ~~registered as provided in this chapter~~ .

§ 32.1-250. Duties of Board.—A. The Board shall ~~establish~~ *install* , maintain and operate ~~a~~ *the only* system of vital records ~~and health statistics~~ throughout this Commonwealth ~~in~~

~~conformity with the provisions of this chapter and provide a center for health statistics to perform data program development, reporting, systems operations, analysis and consultation for the Department, for county and city departments of health and other public agencies having health-related duties~~ .

B. ~~The Board shall safely preserve the records filed with the Department pursuant to this chapter or data obtained therefrom by providing suitable repositories and appropriate equipment for the handling of such records and data.~~

C. ~~In its regulations the Board shall prescribe the exclusive forms upon which the information required by this chapter is to be reported and shall establish a schedule for the disposal of original vital records if the information in such vital records is preserved in a manner satisfactory to the Board.~~

§ 32.1-251. State Registrar; appointment.—The Commissioner shall appoint a State Registrar of Vital Records ~~and Health Statistics~~ *hereinafter referred to as "State Registrar* ."

§ 32.1-252. Same; duties.—A. The State Registrar, under the supervision of the Commissioner, shall:

1. ~~Carry out~~ *Administer* the provisions of this chapter and the regulations of the Board in a manner that will ensure the uniform and efficient administration of the system of vital records ~~and health statistics~~ .

2. *Direct and supervise* ~~Supervise the center for health statistics~~ *the system of vital records and be custodian of its records* .

3. Direct, supervise and control the activities of ~~county, city and special registrars~~ *all persons when pertaining to the operation of the system of vital records* .

4. ~~Prepare and publish reports of health statistics of this Commonwealth and such other reports as may be required by the Commissioner or the Board.~~

5. ~~Serve as custodian of the vital records registered with the Department, arrange, bind and permanently preserve in a systematic manner the certificates of all births, deaths, marriages and divorces registered with the Department or data derived therefrom and prepare and maintain a comprehensive and continuous index of such certificates and data.~~

6. Conduct training programs to promote uniformity ~~in the application of this chapter~~ *of policy and procedures throughout the Commonwealth in matters pertaining to the system of vital records* .

7. Inspect vital records which have been sealed as provided by law whenever such inspection will facilitate the administration of this chapter without violating the confidentiality of such records.

8. Perform such other duties as may be required by law.

9. Develop, furnish and distribute, in accordance with the regulations of the Board, forms as required by this chapter and such other means for transmission of data as may be necessary for the purpose of complete and accurate reporting and registration.

B. The State Registrar may delegate functions and duties vested in him to designated assistants and to county, city and special registrars as he deems necessary or expedient.

§ 32.1-256. Fees of special registrars.—A. Each special registrar not employed by any federal, ~~State~~ *state* or local agency shall be paid the sum of one dollar for each certificate of birth, death or fetal death registered by him and transmitted to the county or city registrar of vital records ~~and health statistics~~ .

B. If no birth, death or fetal death is registered by him during any calendar month, such special registrar shall report that fact to the county or city registrar of vital records ~~and health statistics~~ and shall be paid the sum of one dollar for each such month.

C. The State Registrar shall certify to the treasurer of the county or city quarterly the number of birth, death and fetal death certificates registered by such special registrar, with the name of such special registrar and the amount due. Upon such certification, the fees due such special registrar shall be paid by the treasurer of the appropriate county or city.

§ 32.1-257. Filing birth certificates; from whom required; signatures of parents.—A. A certificate of birth for each live birth which occurs in this Commonwealth shall be filed with the registrar of the district in which the birth occurs within seven days after such birth and shall be registered by such registrar if it has been completed and filed in accordance with this section ; ~~provided, that when a birth occurs in a moving conveyance a birth certificate shall be filed in the district in which the child was first removed from the conveyance~~ .

B. When a birth occurs in an institution *, or enroute thereto,* the person in charge of such institution or his designated representative shall obtain the personal data, prepare the certificate, secure the signatures required by the certificate and file it with the registrar. The physician in attendance shall certify to the facts of birth and provide the medical information required by the certificate within five days after the birth.

C. When a birth occurs outside an institution, the certificate shall be prepared and filed by one of the following in the indicated order of priority:

1. The physician in attendance at or immediately after the birth, or in the absence of such physician,

2. Any other person in attendance at or immediately after the birth, or in the absence of such a person,

3. The father, the mother, or, in the absence of the father and the inability of the mother, the person in charge of the premises where the birth occurred.

C.1. When a birth occurs on a moving conveyance within the United States of America and the child is first removed from the conveyance in this Commonwealth, the birth shall be registered in this Commonwealth and the place where the child is first removed from the conveyance shall be considered the place of birth. When a birth occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the child is first removed from the conveyance in this Commonwealth, the birth shall be registered in this Commonwealth although the certificate shall indicate the actual place of birth insofar as can be determined.

D. If the mother of a child is not married to the natural father of the child at the time of birth or was not married to the natural father at any time during the ten months next preceding such birth, the name of the father shall not be entered on the certificate of birth without ~~the written consent~~ *a sworn acknowledgement of paternity, executed subsequent to the birth of the child,* of both the mother and of the person to be named as the father unless a determination of paternity has been made by a *circuit* court ~~of competent jurisdiction~~ of the Commonwealth, in which case the name of the father as determined by the court shall be entered.

Children born of marriages prohibited by law, deemed null or void or dissolved by a court shall nevertheless be legitimate and the birth certificate for such children shall contain full information concerning the father.

A child born of a married woman, who conceived the child by means of artificial insemination with consent of her husband, shall be deemed legitimate and the birth certificate of such child shall contain full information concerning the mother's husband as the father of the child.

In the event any person desires to have the name of the father entered on the certificate of birth based upon the judgment of paternity of a court of another state, such person shall apply to an appropriate circuit court of the Commonwealth for an order reflecting that such circuit court ~~(i)~~ has reviewed such judgment of paternity and ~~(ii)~~ has determined that such judgment of paternity was amply supported in evidence and legitimate for the purposes of Article IV, Section 1 of the United States Constitution.

If the order of ~~the circuit court is~~ *paternity should be* appealed, the registrar shall not enter the name of the alleged father on the certificate of birth during the pendency of such appeal.

E. Either of the parents of the child shall sign the certificate of live birth to attest to the accuracy of the personal data entered thereon, in time to permit the filing within the seven days prescribed above.

§ 32.1-258. Report of foundling; constitutes birth certificate.—A. Whoever assumes the custody of a living infant of unknown parentage shall report on a form and in the manner prescribed by the Board within seven days to the registrar of the county or city in which such child was found, the following information:

1. The date and place of finding;

2. Sex, race and approximate ~~age~~ *birth date* of such child;

3. Name and address of the persons or institution with whom such child has been placed for care;

4. Name given to such child by the custodian *of the child* ; and

5. Such other data as may be required by the Board.

B. The place where such child was found shall be entered as the place of birth ~~and the date of birth shall be determined by approximation~~ .

C. A report registered ~~under~~ this section shall constitute the certificate of birth for such infant.

D. If such child is identified and a certificate of birth is found or obtained, any report registered under this section shall be sealed and filed and may be opened only by order of a circuit court of the Commonwealth or in accordance with § 32.1-252 A 7.

§ 32.1-259. Filing and registration of delayed birth certificates; refusal of registration; notice of right of appeal.—A. When the birth of a person born in this Commonwealth has not been registered, a certificate may be prepared and filed in accordance with regulations of the Board. Such certificate shall be registered subject to such documentary evidence

requirements as the Board shall by regulation prescribe to substantiate the alleged facts of birth.

B. A certificate of birth registered one year or more after the date of birth shall be *recorded on forms prescribed and furnished by the Board,* marked "Delayed" and shall show on the face the date of the delayed registration.

C. A summary statement of the evidence submitted in support of the delayed registration shall be endorsed on the certificate.

D. 1. When an applicant does not submit the ~~minimum documentary evidence~~ *documentation* required in the regulations for delayed registration or when the State Registrar finds reason to question the validity or adequacy of the proposed certificate or the documentary evidence, *if the deficiencies are not corrected,* the State Registrar shall not register the delayed certificate *of birth* and shall notify the applicant of the reasons for this action ~~. In the event the deficiencies are not corrected, the State Registrar~~ *and* shall *also* advise the applicant of his ~~right to~~ petition for a court order pursuant to § 32.1-260.

2. The Board may by regulation provide for the dismissal of an application which is not actively pursued.

§ 32.1-260. Petition for court order establishing record of birth when delayed certificate rejected; hearing; notice; findings; registration of court order.—A. If a delayed certificate of birth is rejected under the provisions of § 32.1-259, a petition for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered may be filed with the circuit court of the county or city in which the person resides; or if the person is a citizen of this Commonwealth without a fixed residence or a resident of another state, the petition may be to the circuit court of the county or city in which such person's birth occurred. In case of a minor who has no parent or guardian, the application may be made by his next friend.

B. Such petition shall allege:

1. That the person for whom a delayed certificate of birth is sought was born in this Commonwealth;

2. That no record of birth of such person can be found in the records of the State Registrar or the county or city registrar;

3. That diligent efforts by the petitioner have failed to obtain the evidence required by regulations pursuant to § 32.1-259; and

4. That the State Registrar has refused to register a delayed certificate of birth ~~.~~ *; and*

5. Such other allegations as may be required.

C. The petition shall be accompanied by the notice of the State Registrar made in accordance with § 32.1-259 D 1 and all documentary evidence which was submitted to the State Registrar in support of such registration.

D. The court shall fix a time and place for hearing the petition and the petitioner shall give the State Registrar five days' notice of said hearing. The State Registrar, or his authorized representative, may appear and testify in the proceeding.

E. If the court finds from the evidence presented that the person for whom a delayed certificate of birth is sought was born in this Commonwealth, it shall make findings as to the place and date of birth, parentage, and such other findings as ~~the case~~ may ~~require~~ *be required* and shall issue an order ~~on a form furnished by the State Registrar~~ to establish a record of birth *on a form furnished by the State Registrar* . This order shall include the birth data to be registered, a description of the evidence presented in the manner prescribed by § 32.1-259, and the date of the court's action.

F. The clerk of ~~such~~ court shall forward each such ~~order~~ *form* to the State Registrar not later than the tenth day of the calendar month following the month in which ~~it~~ *the order* was entered. Such ~~order~~ *form* shall be registered by the State Registrar and shall constitute the ~~record~~ *certificate* of birth, from which ~~copies~~ *certifications* may be issued in accordance with § 32.1-272.

§ 32.1-261. New birth certificate established on proof of adoption, legitimation or determination of paternity.—A. The State Registrar shall establish a new certificate of birth for a person born in this Commonwealth ~~when the State Registrar receives~~ *upon receipt of* the following:

1. An adoption report as provided in § 32.1-262 . *a report of adoption prepared and filed in accordance with the laws of another state or foreign country,* or a certified copy of the decree of adoption together with the information necessary to identify the original certificate of birth and to establish a new certificate of birth; except that a new certificate of birth shall not be established if so requested by the court decreeing the adoption, the adoptive parents, or the adopted person if eighteen years of age or older.

2. A request that a new certificate be established and such evidence as may be required by regulation of the Board proving that such person has been legitimated or that

a circuit court of the Commonwealth has determined the paternity of such person.

B. When a new certificate of birth is established pursuant to subsection A of this section, the actual place and date of birth shall be shown. It shall be substituted for the original certificate of birth. Thereafter, the original certificate and the evidence of adoption, paternity or legitimation shall be sealed and filed and not be subject to inspection except upon order of a circuit court of this Commonwealth or in accordance with § 32.1-252 A 7.

B.1. Upon receipt of a report of an amended decree of adoption, the certificate of birth shall be amended as provided by regulation.

C. Upon receipt of notice *or decree* of annulment of adoption, the original certificate of birth shall be restored to its place in the files and the new certificate and evidence shall not be subject to inspection except upon order of a circuit court of this Commonwealth or in accordance with § 32.1-252 A 7.

D. The State Registrar shall establish and register a Virginia certificate of birth for a person born in a foreign country and for whom a final order of adoption has been entered in a circuit court of this Commonwealth when the State Registrar receives an adoption report as provided in § 32.1-262 and a request that such a certificate be established and registered; ~~provided,~~ however, ~~that~~ a Virginia certificate of birth shall not be established or registered if so requested by the court decreeing the adoption, the adoptive parents or the adopted person if eighteen years of age or older. After registration of the birth certificate in the new name of the adopted person, the State Registrar shall seal and file the report of adoption which shall not be subject to inspection except upon order of a circuit court of this Commonwealth or in accordance with § 32.1-252 A 7. The birth certificate shall show the true or probable foreign country of birth and shall state that the certificate is not evidence of United States citizenship for the child for whom it is issued or for the adoptive parents.

E. If no certificate of birth is on file for the person for whom a new certificate is to be established under this section, a delayed certificate of birth shall be filed with the State Registrar as provided in § 32.1-259 or *§* 32.1-260 before a new certificate of birth is established, except that when the date and place of birth and parentage have been established in the adoption proceedings, a delayed certificate shall not be required.

§ 32.1-262. Records of adoptions.—A. For each adoption decreed by a court in this Commonwealth, the court shall require the preparation of a report of adoption on a form furnished by the State Registrar. The report (i) shall include such facts as are necessary to locate and identify the original certificate of birth of the person adopted or, in the case of a person who was born in a foreign country, evidence from sources determined to be reliable by the court as to the date, place of birth and parentage of such person; (ii) shall provide information necessary to establish a new certificate of birth of the person adopted; and (iii) shall identify the order of adoption and be certified by the clerk of court.

B. Information in the possession of the petitioner necessary to prepare the report of adoption shall be furnished with the petition for adoption by each petitioner for adoption or by his attorney. In all cases where a child is placed for adoption by a child-placing agency, the report shall be completed and filed with the court by a representative of the agency.

C. On or before the tenth day of each month, the clerk of such court shall forward to the State Registrar all records of decrees of adoption entered in the preceding calendar month, together with such related reports as the State Registrar may require.

D. When the State Registrar receives a ~~record~~ *report* of adoption *, annulment of adoption* ~~from~~ ~~a~~ ~~court~~ *, amendment, or amendment of a decree of adoption* for a person born outside this Commonwealth, such ~~record~~ *report* shall be forwarded to the appropriate registration authority in the state of birth. When the State Registrar shall receive a ~~record~~ *report* of adoption from a court in this Commonwealth for a person born in a foreign country, a birth certificate shall be registered for such person in accordance with the provisions of § 32.1-261, and a copy of the report of adoption shall be transmitted to the appropriate federal agency.

§ 32.1-263. Filing death certificates; medical certification; investigation by medical examiner.—A. A death certificate for each death which occurs in this Commonwealth shall be filed with the registrar of the district in which the death occurred within three days after such death and prior to final disposition or removal of the body from the Commonwealth, and shall be registered by such registrar if it has been completed and filed in accordance with this section; provided:

1. That if the place of death is unknown, *but the dead body is found in this Commonwealth,* a death certificate shall be filed in the registration district in which ~~a~~ *the* dead body is found ~~within three days after discovery of such body~~ *in accordance with this section. The place where the dead body is found shall be shown as the place of death. If*

the date of death is unknown, it shall be determined by approximation ; and

2. That ~~if~~ *when* death occurs in a moving conveyance, ~~a death certificate shall be filed in the registration district in which the dead body was first removed from such conveyance~~ *in the United States of America and the body is first removed from the conveyance in this Commonwealth, the death shall be registered in this Commonwealth and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in this Commonwealth, the death shall be registered in this Commonwealth but the certificate shall show the actual place of death insofar as can be determined.*

B. The funeral director or person who first assumes custody of a dead body shall ~~obtain the personal data, prepare the certificate, secure the signatures required by the certificate and~~ file ~~it~~ *the certificate of death* with the registrar. He shall obtain the personal data from the next of kin or the best qualified person or source available ~~. He~~ *and* ~~shall~~ obtain the medical certification ~~of cause of death~~ from the person responsible ~~for preparing the same as provided in this section~~ *therefor* .

C. The medical certification ~~portion of the death certificate~~ shall be completed ~~and~~ , signed *and returned to the funeral director* within twenty-four hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death except when inquiry or investigation by a medical examiner is required by § 32.1-283.

In the absence of the physician or with his approval, the certificate may be completed and signed by an associate physician, the chief medical officer of the institution in which death occurred, or the physician who performed an autopsy upon the decedent, if such individual has access to the medical history of the case and death is due to natural causes.

D. When inquiry or investigation by a medical examiner is required by § 32.1-283, the medical examiner shall investigate the cause of death and shall complete and sign the medical certification portion of the death certificate within twenty-four hours after being notified of the death. If the medical examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and sign the medical certification portion of the death certificate.

E. ~~In any case where an autopsy is performed, the physician pathologist may complete and sign the medical certification portion of the death certificate.~~

F. If the cause of death cannot be determined within twenty-four hours after death, the medical certification shall be completed as provided by regulations of the Board. The attending physician or medical examiner shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician or medical examiner.

§ 32.1-264. Reports of fetal deaths; medical certification; investigation by medical examiner; confidentiality of information concerning abortions.—A. A fetal death report for each fetal death which occurs in this Commonwealth shall be filed, on a form furnished by the State Registrar, with the registrar of the district in which the delivery occurred or the abortion was performed within three days after such delivery or abortion and shall be registered with such registrar if it has been completed and filed in accordance with this section; provided that:

1. If the place of fetal death is unknown, a fetal death report shall be filed in the registration district in which a dead fetus was found within three days after discovery of such fetus; and

2. If a fetal death occurs in a moving conveyance, a fetal death report shall be filed in the registration district in which the fetus was first removed from such conveyance.

B. The funeral director or person who first assumes custody of a dead fetus or, in the absence of a funeral director or such person, the hospital representative who first assumes custody of a fetus shall file the fetal death report; in the absence of such a person, the physician or other person in attendance at or after the delivery or abortion shall file the report of fetal death. The person completing the forms shall obtain the personal data from the next of kin or the best qualified person or source available, and he shall obtain the medical certification of cause of death from the person responsible for preparing the same as provided in this section. In the case of induced abortion, such forms shall not identify the patient by name.

C. The medical certification portion of the fetal death report shall be completed and signed within twenty-four hours after delivery or abortion by the physician in attendance at or after delivery or abortion except when inquiry or investigation by a medical examiner is

D. When a fetal death occurs without medical attendance upon the mother at or after the delivery or abortion or when inquiry or investigation by a medical examiner is required, the medical examiner shall investigate the cause of fetal death and shall complete and sign the medical certification portion of the fetal death report within twenty-four hours after being notified of the fetal death.

E. ~~The information obtained and the~~ *The* reports ~~prepared~~ *required* pursuant to this section ~~shall be used only for~~ statistical purposes *are statistical reports to be used only for medical and health purposes and shall not be incorporated into the permanent official records of the system of vital records. A schedule for the disposition of these reports may be provided by regulation .*

§ 32.1-269. Amending vital records; change of name; acknowledgment of paternity; change of sex.—A. A vital record registered under this chapter may be amended *only* in accordance with this article and such regulations as may be adopted by the Board to protect the integrity and accuracy of such vital records. Such regulations shall specify the minimum evidence required for a change in any such vital record. ~~If the State Registrar finds reason to question the validity or sufficiency of the evidence, the vital record shall not be amended and he shall so advise the applicant. An aggrieved applicant may petition the circuit court of the county or city in which he resides or the Circuit Court of the city of Richmond, Division I, for an order compelling the State Registrar to amend the vital record. The State Registrar or his authorized representative may appear and testify in such proceeding.~~

B. Except in the case of an amendment provided for in subsection D, a vital record that is amended under this section shall be marked "amended" and the date of amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made a part of the vital record. The Board shall prescribe by regulation the conditions under which omissions or errors on certificates, including designation of sex, may be corrected within one year after the date of the event without the certificate being ~~considered as~~ *marked* amended. In a case of hermaphroditism or pseudo-hermaphroditism, the certificate of birth may be corrected at any time without being considered as amended upon presentation to the State Registrar of such medical evidence as the Board may require by regulation.

C. Upon receipt of a certified copy of a court order changing the name of a person as listed in a vital record and upon request of such person or his parent, guardian, or legal representative or the registrant, the State Registrar shall amend such vital records to reflect the new name.

D. Upon *written* request *of both parents* and receipt of a sworn acknowledgment of paternity ~~of a child born out of wedlock signed by both~~ parents *executed subsequent to the birth and signed by both parents of a child born out of wedlock* , the State Registrar shall amend the certificate of birth to show such paternity if paternity is not shown on the birth certificate. Upon request of the parents, the surname of the child shall be changed on the certificate to that of the father.

E. Upon ~~submission~~ *receipt* of ~~evidence required by regulation of the Board proving~~ *a certified copy of an order of a court of competent jurisdiction indicating* that ~~a person~~ *the sex of an individual* has ~~had a change of sex~~ *been changed* by medical procedure and upon request of such person, the State Registrar shall amend such person's certificate of birth to show the change of sex and, if a certified copy of a court order changing the person's name is submitted, to show a new name.

F. When an applicant does not submit the minimum documentation required by regulation to amend a vital record or when the State Registrar finds reason to question the validity or sufficiency of the evidence, the vital record shall not be amended and he shall so advise the applicant. An aggrieved applicant may petition the circuit court of the county or city in which he resides or the Circuit Court of the City of Richmond. Division I, for an order compelling the State Registrar to amend the vital record. The State Registrar or his authorized representative may appear and testify in such proceeding.

§ 32.1-270. State Registrar may reproduce records.—To preserve original documents, the State Registrar is authorized to prepare ~~reproductions of original vital records by~~ typewritten, photographic, ~~or~~ electronic means *, or other reproductions of original vital records in his custody* . Such reproductions when certified by him shall be ~~used~~ *accepted* as the original *records* .

The documents from which permanent reproductions have been made and verified may be disposed of as provided by regulation.

§ 32.1-271. Unlawful disclosure of information in records.—A. To protect the integrity ~~of the system~~ of vital records ~~and health statistics~~ and to ~~insure~~ *ensure* the *efficient and* proper ~~use~~ *administration of the system* of vital records, it shall be unlawful,

notwithstanding the provisions of §§ 2.1-340.1 through 2.1-346.1, for any person to permit inspection of or to disclose information contained in vital records or to copy or issue a copy of all or part of any such vital records except as authorized by regulation of the Board or when so ordered by a circuit court of this Commonwealth.

B. Data contained in vital records may be disclosed for valid and substantial research purposes in accordance with the regulations of the Board.

C. Any person aggrieved by a decision of a county or city registrar may appeal to the State Registrar. If the State Registrar denies disclosure of information or inspection of or copying of vital records, such person may petition the circuit court of the county or city in which he resides if he resides in the Commonwealth or in which the recorded event occurred or the Circuit Court of the ~~city~~ *City* of Richmond, Division I, for an order compelling disclosure, inspection or copying of such vital record. The State Registrar or his authorized representative may appear and testify in such proceeding.

D. When 100 years have elapsed after the date of birth, or fifty years have elapsed after the date of death, marriage, or divorce, the records of these events in the custody of the State Registrar may become public records and information be made available in accordance with regulations which shall provide for the continued safekeeping of the records. All records, which are public information on the effective date of this act, shall continue to be public information.

§ 32.1-272. Certified copies of vital records; other copies.—A. In accordance with § 32.1-271 and the regulations adopted pursuant thereto, the State Registrar shall, upon *receipt of a written* request, issue a certified copy of any vital record in his custody or of a part thereof. Such vital records in his custody may be in the form of originals, photoprocessed reproductions or data filed by electronic means. Each copy issued shall show the date of registration. Any copy issued from a record marked "delayed ~~,~~ " *or* "amended, " ~~or "court order,"~~ except a record amended pursuant to subsection F of this section or subsection D of § 32.1-269, shall be similarly marked and show the effective date. Certified copies may be issued by county and city registrars only while the original record is in their possession, except that at the option of the county or city registrar true and complete copies of death certificates may be retained and certified copies of such records may be issued by the county or city registrar.

B. A certified copy of a vital record or any part thereof issued in accordance with subsection A shall be considered for all purposes the same as the original and shall be prima facie evidence of the facts therein stated, provided that the evidentiary value of a vital record filed more than one year after the event or a vital record which has been amended shall be determined by the judicial or administrative body or official before whom the certificate is offered as evidence.

C. The federal agency responsible for national vital ~~and health~~ statistics may be furnished such copies or *other* data *from the system of vital records* as it may require for national statistics ~~and~~ *if* such *federal agency shares in the cost of collecting, processing and transmitting such data. Such* data ~~as~~ may be ~~necessary~~ *used* for research and medical investigations of public health importance. No other use of such data shall be made by the federal agency unless authorized by the State Registrar. ~~The Commonwealth shall be reimbursed for the cost of furnishing such data.~~

D. ~~Federal~~ *Other federal* , ~~State~~ ~~,~~ *state and* local, ~~and other~~ public *or private* agencies in the conduct of their official duties may, upon request *and payment of a reasonable fee* , be furnished copies or *other* data *from the system of vital records* for statistical or ~~verification~~ *administrative* purposes upon such terms or conditions as may be prescribed by the Board. *Such copies or other data shall not be used for purposes other than those for which they were requested unless so authorized by the State Registrar.*

E. No person shall prepare or issue any certificate which purports to be an original, certified copy, or copy of a ~~certificate of birth, death, or fetal death~~ *vital record* except as authorized in this chapter or regulations adopted hereunder.

F. Certified copies of birth records filed before July ~~one, nineteen hundred sixty~~ *1, 1960* , containing statements of racial designation on the reverse thereof shall be issued without such statement as a part of the certification; nor for this purpose solely shall such certification be marked "amended."

§ 32.1-273. Fees for certified copies, searches, certain birth certificates, amendments and information; disposition.—A. The Board shall prescribe the fee, not to exceed ~~three~~ *five* dollars, for a certified copy of a vital record or for a search of the files or records when no copy is made ~~, and not to exceed five dollars for processing and issuing one certified copy of a delayed birth certificate pursuant to the provisions of § 32.1-258 or § 32.1-260, for establishing a birth certificate pursuant to § 32.1-261, for amending a vital record pursuant to § 32.1-269, or~~ *and may establish a reasonable fee schedule related to its cost* for

information *or other data* provided for research, statistical or administrative purposes. ~~For each additional copy of a death certificate, a fee not to exceed one dollar may be prescribed by the Board.~~

B. Fees collected under this section by the State Registrar shall be ~~deposited in the general fund of the State treasury~~ *transmitted to the Comptroller for deposit. Two dollars of each fee collected by the State Registrar shall be deposited by the Comptroller into the Vital Statistics Automation Fund established pursuant to § 32.1-273.1 for so long as shall be authorized. The remainder shall be deposited into the general fund of the state treasury. When the Vital Statistics Automation System is completed, no further deposits into the Fund shall be made and all fees collected under this section shall be deposited into the general fund of the state treasury* .

C. Fees collected under this section by county and city registrars shall be deposited in the general fund of the county or city except that counties or cities operating health departments pursuant to the provisions of § 32.1-31 shall forward all such fees to the Department for deposit in the cooperative local health services fund.

§ 32.1-274. Persons in charge of institutions and funeral directors, etc., to keep records; lists sent to State Registrar.—A. Every person in charge of an institution shall keep a record *of personal data* concerning each person admitted or confined to such institution ~~which~~ . *This record* shall include such information as required ~~by the standard certificate~~ *for the certificates* of birth, death, and *reports of spontaneous* fetal death ~~forms issued under the provisions of~~ *and induced termination of pregnancy required by* this chapter. The record shall be made at the time of admission from information provided by ~~such~~ *the* person *being admitted or confined* , but when it cannot be so obtained, the ~~same~~ *information* shall be obtained from relatives or other persons acquainted with the facts. The name and address of the person providing the information shall be a part of the record.

B. When a dead human body is released or disposed of by an institution, the person in charge of the institution shall keep a record showing the name of the deceased, date of death, the name and address of the person to whom the body is released and the date of removal from the institution, or, if final disposal is by the institution, the date, place, and manner of disposition.

C. A funeral director, embalmer, or other person who removes from the place of death or transports or is in charge of final ~~disposal~~ *disposition* of a dead body or fetus, in addition to filing any certificate, report or form required by this chapter, shall keep a record which shall identify the body, and such information pertaining to his receipt, removal, and delivery of such body as may be prescribed in regulations adopted by the Board.

D. Not later than the tenth day of the month following the month of occurrence, the administrator of each institution shall cause to be sent to the State Registrar a list showing thereon all births, deaths, and fetal deaths occurring in such institution during the preceding month. Such lists shall be on forms provided by the State Registrar.

E. Not later than the tenth day of the month following the month of occurrence, each funeral director shall send to the State Registrar a list showing thereon all caskets furnished, bodies prepared for disposition and transportation and funerals performed where no casket was furnished by the funeral director during the preceding month. Such lists shall be on forms provided by the State Registrar.

F. Records maintained under this section shall be retained for a period of not less than ten years and shall be made available for inspection by the State Registrar or his representative upon demand.

§ 32.1-275.1. Matching of birth and death certificates.—To protect the integrity of vital records and prevent the fraudulent use of birth certificates of deceased persons, the State Registrar is hereby authorized to match birth and death certificates, in accordance with regulations promulgated by the Board, to prove beyond a reasonable doubt the fact of death, and to post the facts of death to the appropriate birth certificate. Copies issued from birth certificates marked deceased shall be similarly marked.

§ 32.1-276. Penalty imposed for violations.—Any person *who commits any of the following acts is guilty of a Class 4 felony* :

1. Who willfully and knowingly makes any false statement in a report, record, or certificate required to be filed under this chapter, or in an application for an amendment . *certification or verification* of any such report, record or certificate, or who willfully and knowingly supplies false information intending that such information be used in the preparation of any such report, record, or certificate, or amendment thereof; or

2. Who without lawful authority and with the intent to deceive, makes, *counterfeits,* alters, amends, or mutilates any report, record, or certificate required to be filed under this chapter or a certified copy of such report, record, or certificate; or

3. ~~Who willfully and knowingly gives false information in an application for a certificate or for verification of a vital record; or~~

4. ~~Who~~ willfully and knowingly *obtains, possesses,* uses , *sells, furnishes* or attempts to *obtain, possess,* use, *sell,* or ~~furnishes~~ *furnish* to another ~~for use~~ , for any purpose of deception, any certificate, record ~~or~~ report required ~~to be filed under~~ *by* this chapter or certified copy thereof made, *counterfeited,* altered, amended, or mutilated *or which is false in whole or part or which relates to the birth of another person whether living or deceased* without lawful authority ~~and with the intent to deceive~~ ; or

5. ~~Who with the intent to deceive willfully obtains, uses or attempts to use any certificate of birth or certified copy of a record of birth knowing that such certificate or certified copy was issued upon a record which is false in whole or in part or which relates to the birth of another person shall be guilty of a Class 1 misdemeanor.~~

6. Who is an employee of the State Registrar or of the Department of Health while engaged in activities pertaining to the operation of the system of vital records who, without lawful authority, willfully and knowingly furnishes or possesses any certificate, report, record, or certification thereof, with the knowledge or intention that it be used for the purposes of deception; or

7. Who, without lawful authority, possesses any certificate, record, or report required by this chapter or a copy or certification of such certificate, record, or report knowing same to have been stolen or otherwise unlawfully obtained.

CHAPTER 7.1.

HEALTH STATISTICS.

§ 32.1-276.1. Center for Health Statistics; duties of Director.—A. The board shall provide a Center for Health Statistics to perform data program development, reporting, systems operations, analysis and consultation, for the Department of Health, for county and city departments of health and other public agencies having health-related duties.

B. The Director of the Center for Health Statistics, under the supervision of the Commissioner, shall:

1. Supervise the Center for Health Statistics.

2. Collect other health-related records and reports and prepare, tabulate, analyze, and publish vital statistics and other health statistical data of this Commonwealth and such other reports as may be required by the Commissioner or the Board.

2. That § 14.1-91 of the Code of Virginia is repealed.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

APPENDIX B

State/Local Cooperative Budget Formula

The State Health Department has established by regulation that the local share of the cost of operation of district health departments shall be based on the local ability to pay, with the true value of real property in a given locality serving as the basis of measurement. The Department has determined that local financial support shall range from 18% to 45% of the operating costs of the department. The State Department of Health provides technical support at state expense.

The formula for determining the local financial contribution to the operation of a district health department is as follows:

$$\frac{\text{\% of budget to be locally produced} - Y1}{Y2 - Y1} = \frac{X - X1}{X2 - X1}$$

Y1 = 18 (the minimum percentage that any locality must pay toward the cost of the district health department)

Y2 = 45 (the maximum percentage that any locality must pay toward the cost of the district health department)

X = estimated true tax value of real property in the locality under consideration

X1 = estimated true tax value of real property in the locality with the lowest estimated true taxable value

X2 = 391,951,000 (the level of estimated true tax value which would demand a local contribution of 45% of the operating costs of the district health department; localities with true tax values over this amount also pay 45%)

Because the formula is based on the value of the property within a locality, generally speaking, the smaller, (and in the case of counties, the more rural) a locality is, the smaller the proportion of the operating costs it will have to pay.

Prepared by Richard Hall-Sizemore