**2003 REPORT OF THE**
**JOINT COMMISSION ON HEALTH CARE**

# REVIEW OF LOCAL HEALTH PARTNERSHIP AUTHORITIES

**(HB 2060 - 2001 Session)**

Joint Commission on Health Care
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# Preface

House Bill 2060 (2001 General Assembly Session) amended *Code of Virginia* Title 32.1 Chapter 4 by adding Article 6.1 (§§32.1-122.10.001 through 32.1-122.10:005). The provisions of Article 6.1 effectuate the following:

- Authorizes single or multi-jurisdictional health care partnership authorities to allow government and private entities to join forces to address the health care needs of an area:
  - Pilot project in Planning District 8 established
  - Required evaluation of the pilot project by JCHC by November 2002;
- Provides basic outline for the local authority with provisions for membership, board of directors, meeting and voting requirements, and outline of powers and duties;
- Requires approval by each participating locality;
- Allows for disclosure of medical records;
- Protects volunteers from civil liability for noninvasive or minimally invasive procedures; and
- Includes sunset provision for July 1, 2003.

A copy of HB 2060 as adopted iS included in Appendix A.

The pilot project, the Prince William Health Partnership Authority (PWHPA), is an outgrowth of the *Turning Point* Program. *Turning Point* was a national program initiated in 1997 by W.K. Kellogg and Robert Wood Johnson Foundations. Under the auspices of *Turning Point,* Prince William completed a community health assessment that indicated the need for improvements in the delivery of health care services to address duplication, inefficiency, and gaps in health care services. A multi-jurisdictional "Health Authority" was proposed in collaboration with local public officials and HB 2060 was introduced and enacted during 2001.

As a local health partnership authority, PWHPA does not expect to rely on state or local funding to support its operations:

- Operations have been supported by the two area hospitals;

- A non-stock corporation known as Prince William Partners, Inc. was recently established
  - 501(c)3 status to be a holding company;
- Future financial support is expected to come from grants, corporate contributions, fundraising and donations
  - Grants have not been aggressively pursued nor have fundraising events been scheduled due to the sunset date on PWHPA's authorizing legislation.

The mission of PWHPA is "to develop and assist partnerships among the public and community non-profit providers. We will assist in planning, sharing resources, reducing barriers and implementing strategies to address the health care needs and improve the quality and availability of health care in the Prince William area."

PWHPA will focus on two community health issues in the next few years:

- Waist Management – programs and educational activities to curb obesity and reduce the number of area residents who are overweight; and
- Healthy Children for a Healthy Future – programs to promote overall health and wellness in children.

**Evaluation of PWHPA** Considering PWHPA's stage of development, no assessment could be made of the Authority's ability to secure funding or to carry out programs. PWHPA has strong support from local officials and organizations but the sunset date of July 2003 has been a significant barrier to initiating programs.

It is difficult at this juncture to make any judgments regarding the advisability of allowing additional local heath partnership authorities on a permanent basis.

## Actions Taken by JCHC

A number of policy options were offered by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on page 27. A summary of the public comments received regarding the proposed Options are included in Appendix B.

JCHC took the following actions with regard to the study Options:

- Approved Option II to introduce legislation to extend the sunset date from July 1, 2003 to July 1, 2006.
- Amended and approved Option IV to introduce legislation to require annual reports to the Joint Commission.

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# I.
# Authority for the Study/Organization of Report

House Bill 2060 of the 2001 General Assembly Session authorized, as a pilot project, the creation of a local health partnership authority in Planning District 8 (Prince William County and the cities of Manassas and Manassas Park). The legislative summary of HB 2060 reads:

> Creates the authority for single or multijurisdictional health care partnership authorities where government and private entities may join forces to address the health care needs of the area and assist in providing such services in a coordinated manner so as to eliminate duplication and inefficiency. The bill provides the basic outline for a local authority with provisions for membership, a board of directors, meeting and voting requirements and an outline of powers and duties. The authority would have to be approved by each participating locality by ordinance, resolution or agreement only after a public hearing has been held. The bill also has provisions that (i) allow for the disclosure of medical records to the authority to allow for health care services to be provided, and (ii) protect volunteers from civil liability for acts or omissions when providing noninvasive and minimally invasive procedures limited to finger sticks and injections performed as part of health care services unless the acts or omissions were the result of gross negligence or willful misconduct. The State Department of Health must choose the multi-jurisdictional effort that has been operating a community health program under a grant from the Robert Woods Johnson and Kellogg Foundations in Planning District 8 to act as a pilot for this concept. The Joint Commission on Health Care is required to monitor and provide technical advice to the pilot project and to evaluate the program by November 15, 2002. This provision sunsets on July 1, 2003.

As noted, the Joint Commission on Health Care (JCHC) is required to evaluate the program by November 15, 2002.

A copy of HB 2060 as adopted is included in Appendix A.

## Organization of Report

This report is presented in five major sections. This section discussed the authority for this study of the local health partnership that was established in Planning District 8. Section II provides background and describes the current operation of the partnership known as the Prince William Health Partnership Authority (PWHPA). Section III is a copy of the report that was submitted to JCHC by PWHPA in September 2002. Section IV evaluates the progress made by the PWHPA to date. Section V provides a series of policy options the Joint Commission on Health Care may wish to consider.

# II.
# Background/Current Operation

The Prince William Health Partnership Authority is an outgrowth of work that was undertaken by the Prince William Partnerships for Health. The Prince William Partnerships for Health was one of three local partnerships in Virginia to receive grant funding through the *Turning Point* program. *Turning* Point was a national program initiated in 1997 by the W. K. Kellogg and Robert Wood Johnson Foundations in order to "transform and strengthen public health to meet the challenges of the 21st century."

The Prince William Partnerships for Health was a "coalition comprised of representatives of public health, health care, not-for-profit organizations, volunteer organizations, mental health, special interest groups, education, elected officials, and the faith community" from Prince William County and the cities of Manassas and Manassas Park. The Partnerships completed a community health assessment gathering information from area residents through 31 focus-group meetings about improving community health. The community assessment revealed the need for improvements in the delivery of health care services to address duplication, inefficiency, and gaps in health care services. To address these community needs, a multi-jurisdictional "Health Authority" was proposed in collaboration with local public officials. HB 2060 was introduced and enacted during the 2001 Session of the General Assembly to provide the legal framework needed to authorize the health authority concept.

HB 2060 amended *Code of Virginia* Title 32.1, Chapter 4 by adding Article 6.1 (§§ 32.1-122.10:001 through 32.1-122.10:005). The provisions of Article 6.1 effectuate the following:

- Authorizes single or multi-jurisdictional health care partnership authorities allowing government and private entities to join forces to address the health care needs of the area and to assist in providing such services in a coordinated manner to eliminate duplication and inefficiency;

- Provides basic outline for a local authority with provisions for membership, a board of directors, meeting and voting requirements, and an outline of powers and duties;

- Requires approval of the local authority by each participating locality by ordinance, resolution or agreement only after a public hearing has been held;

- Allows for disclosure of medical records to the local authority to allow health services to be provided;

- Protects volunteers from civil liability for acts or omissions when providing noninvasive and minimally invasive procedures limited to finger sticks and injections;

- Establishes a pilot project in Planning District 8 in a community health program operating under the auspices of the Robert Wood Johnson and Kellogg Foundations;

- Directs the Joint Commission on Health Care to monitor and provide technical advice to the pilot authority; evaluate the program by November 15, 2002; and make recommendations regarding the continuation of the authority, the expansion to other areas of the state, and any necessary changes; and

- Stipulates that the provisions of HB 2060 will expire on July 1, 2003.

**Current Operation of the Prince William Health Partnership Authority**

Figure 1 shows the dates that certain key activities were accomplished by the Prince William Health Partnership Authority. (A more extensive list of activities is shown in the next section which contains the Report that was submitted by PWHPA to JCHC.) As noted in Figure 1, the three participating localities all adopted resolutions by September 2001, but the Board of Directors for PWHPA was not formed until March 2002. PWHPA by-laws require the Board to be comprised at a minimum of "one locally elected official, one representative of the health care industry, one representative of the business community, and one representative of the non-governmental human services agencies from each participating locality; and sufficient citizen members to constitute the majority of the Board...." There are currently 15 Board members of whom nine are citizen members.

**Figure 1**
**Dates that Selected Activities Were Accomplished by the Authority**

| | |
|---|---|
| **September 2001** | Resolutions authorizing participation in the Partnership Authority passed by Prince William County, Manassas and Manassas Park |
| **January 2002** | Executive Director for the Authority hired |
| **March 2002** | Appointments to the Board of Directors made by all three jurisdictions |
| **April 2002** | Authority By-Laws and Articles of Incorporation passed by all three jurisdictions |
| **May 2002** | First Board meeting held |
| **June 2002** | Board meeting held |
| | Authority representatives presented information about the Authority (per invitation) at Community Health Governance Conference in Seattle, Washington |
| **August 2002** | Board meeting held |
| | Day-long retreat for Board members held resulting in adoption of Authority Purpose, Mission Statement, Vision Statement, and Community Program Plans |
| **September 2002** | Board meeting held |

**Source:** Report of the Prince William Health Partnership Authority, September 2002.

To date, PWHPA operations have been supported by the two area hospitals (Potomac Hospital and the Prince William Health System) which donated monetary contributions of $30,000 each and in-kind support including office space and utility expenses. PWHPA established a non-stock corporation known as Prince William Health Partners, Inc. which has applied for 501(c)3 status to act as a "holding company" to receive the funding donated/granted to the Authority. PWHPA does not expect to rely on state or local funding to support its operations noting that financial support is expected to come from grants, corporate contributions, fundraising, and donations. PWHPA has not aggressively pursued grants or undertaken fundraising events due to the sunset date in its current authorizing legislation.

Figure 2 shows the Purpose, Mission Statement, and Vision Statement that were adopted recently by the PWHPA Board. As noted, the Authority is seeking to reduce duplication and build partnerships in order to foster healthier communities throughout the Prince William area.

**Figure 2**
**Purpose, Mission Statement, and Vision Statement**
**Adopted by Board of Prince William Health Partnership Authority**

**Purpose**

- Is to guide, support and coordinate the delivery of health-related services through on-going community assessment and priority setting.

- Through this centralized coordination, PWHPA will minimize duplication of effort and ensure that area health and community services are more accessible to every*body* in need.

**Mission Statement**

The mission of the Health Partnership Authority (PWHPA) is to develop and assist partnerships among the public and community non-profit providers. We will assist in planning, sharing resources, reducing barriers and implementing strategies to address the health care needs and improve the quality and availability of health care in the Prince William area.

**Vision Statement**

The vision of the Prince William Health Partnership Authority is to foster, through a variety of creative and inclusive partnerships, healthier communities within the Prince William area through increased awareness, accessibility and affordability.

**Source:** Report of the Prince William Health Partnership Authority, September 2002.

PWHPA has decided to focus on two community health issues in the next three years. The first issue relates to programs and educational activities that seek to curb obesity and reduce the number of area citizens who are overweight. The PWHPA Report states:

> The Greater Prince William area has the highest proportion of individuals who are overweight and obese, more than any other region in the Greater Washington Metropolitan Region....The Prince William Health Partnership Authority has chosen this initiative as a priority because of the numerous complications and the development of disease-related conditions due to being overweight and obese....[O]besity is the second leading cause of preventable death in the United States. The costs of treating adults with obesity are over $238 billion a year, making it one of the most expensive diseases in the country. It is increasing among all age, gender, racial and ethnic groups, both in the United States and around the world....The Authority will focus on this initiative by increasing awareness, providing greater community education, and by creating partnership

programs [including working with physicians and with community organizations on early detection and prevention].

PWHPA's second health issue, which will address "Healthy Children for a Healthy Future," is still in the early planning stages.

# III.
# Report of the Prince William Health Partnership Authority

## Executive Summary

In February 2001, House Bill (HB) 2060 was passed by the Virginia General Assembly. This legislation provided our community the opportunity and means to address community needs through a multi-jurisdictional "Health Partnership Authority." The Authority concept allows local citizens, government and private entities to join forces in coordinating health-care and health-related services for Greater Prince William.

The purpose of the Prince William Health Partnership Authority (PWHPA) is to guide, support and coordinate the delivery of health-related services through on-going community assessment and priority setting for Greater Prince William. Through this centralized coordination, PWHPA will minimize duplication of effort and ensure that area health and community services are more accessible to every*body* in need. As stated in the legislation, our organization will be a catalyst for "developing partnerships between public and private providers."

Our objective is to seek further ways of improving the health status of Prince William County, and the Cities of Manassas and Manassas Park. The statute outlines the specific purposes/ objectives for our program. These objectives enable us to provide a more comprehensive approach to the care and well being of our community. The following objectives are delineated in the statute:

1. Allow governments to fully participate in such partnerships
2. Encourage the use of service delivery that otherwise might have required government funding or programs
3. Maximize the willingness of individuals, agencies and private organizations to lend their expertise to help satisfy community needs
4. Allow innovative funding mechanisms to leverage public funds
5. Allow appropriate information sharing to ensure the adequacy and quality of services delivered
6. Provide liability protection for volunteers providing services under programs sponsored or approved by the Authority
7. Provide a mechanism to ensure that services provided in the community are necessary, appropriate and provided by trained and supervised persons
8. Allow volunteers and others to focus their energies to achieve community health improvement. Health care services include, but are not limited to, treatment of and education about acute and chronic diseases, wellness and prevention activities that promote the health of communities, and access to services and activities.

The primary goal of the Prince William Health Partnership Authority is to build sustaining support for community health and well being, through partnerships. Thus our

program initiatives will facilitate new health and human services partnership opportunities that are consistent with improving our community's health and health care related services.

We define projects to improve community health and health care related services as those:

1. Enabling underserved and disadvantaged populations greater access to health related services and support

2. Promoting healthy behaviors and lifestyle choices individually and collectively (as a community)

3. Encouraging the adoption of healthy lifestyles and behaviors by individuals and community organizations

4. Addressing social, economic, cultural and community factors that affect individual health and health choices

5. Working to increase the awareness about consequences due to adverse health choices

**What are or will be the organization's sources of financial support?**

a.) Grants revenue(s)
b.) Corporate contributions
c.) Fundraising events and/or activities
d.) Individual donations

**Organization's fundraising program, both actual and planned, and extent it has been put into effect.**

To date, this organization existence is solely because of the corporate contributions received from the Greater Prince William area (includes the County and the Cities of Manassas and Manassas Park) hospitals. Both area hospitals have contributed an equal share of $30,000.00 cash and provided the in-kind donations of office space, utilities, etc. These hospitals are Potomac Hospital and the Prince William Health System. It is the intention of this organization to seek grant funding from private foundations, corporations, and other philanthropic entities for support. This organization is in its infancy, and as of yet, has not created any solicitation materials/documents, other than grant applications. It is also our intention not to create solicitation materials for financial support, until we receive confirmation of our status regarding the "sunset" clause provision.

## Our Hope

**It is our greatest hope that the "sunset clause" be removed from the legislation.**

**Our reasons are as follows:**

**Why are we requesting for the "sunset" clause to be removed? :**

- By having the clause provision there, applying for funding is more difficult because revenue sources (private foundations, corporations, and the Federal Government) are not as likely to give to an entity that they fear will be dissolved before their investment has a change to take root and grow.

- Demonstration to the community that we are a lasting entity; here to improve the health and well-being of the Greater Prince William Area; citizens are more likely to invest their time into the cause, and more importantly their trust. (For Board participation, community programs & projects, and as part of action taskforce(s) or committee(s).)

- Community agencies are more readily willing to participate in collaborative efforts, if they feel that there is a solid basis for their participation and efforts. If our organization becomes an established part of the community, then as being a part of the community framework, we become a resource for where community partnership ideas/practices can come to fruition. We become an entity that citizens and service agencies can rely on to convey ideas, facilitate collaborative programs and help better service our local community's health concerns.

- Lastly, better able to recruit staff to work for Authority.

If "sunset clause" removal is not granted, then the Authority respectfully requests a three-year extension.

**Why a "3-Year Extension"?**

- A three-year extension would allow us more time than the standard one or two-year extension for obtaining qualitative and quantitative statistical outcomes from our program results. By having such statistical outcomes of our goals/results, it is our intention to use this data as further justification for removing the "sunset clause." Programs take time to yield measurable results, if we were only given an extension of one or two-years, the concern is that we would have insufficient numbers to demonstrate the effectiveness of this program entity for the community.

**Lessons Learned:**

1. We had a challenge determining the appropriate Board representation, as explained by the statute. The legislation required each participating jurisdiction include a "non-profit, non-governmental, human services agency." This was not easily accomplished, as a City jurisdiction did not have an agency that met that criteria. To compensate, our largest jurisdiction, felt it was appropriate to name a "non-profit, non-governmental, human services representative" to comply with the statute. If there were some type of clarification in the statute from the General Assembly, it would have helped us determine an appropriate course of action. Although, the other jurisdictions eventually went along with the local interpretation of the statute, the process took several weeks to resolve.

2. Both our by-laws and articles of incorporation were subjected to several reviews and revisions by the largest jurisdiction. The legislation does not specify whether or not the jurisdictions or governing bodies have the power to mandate, change, amend or repeal the by-laws, and other operational documents, *over* the decisions made by the Partnership and/or the Authority's Board of Directors. To approve the existence of the local health partnership authority, the jurisdictions included in their resolution the power to do so. This was a significant stumbling block and took several months to resolve.

   Furthermore, the legislation does not clarify where board appointees are in this process. By not doing so, our *future* Board Directors (citizens included) were precluded from providing their input on the operational procedures (by-laws and articles of incorporation) for the local level of the Authority.

3. Another challenge encountered were interactions between the different jurisdictions involving board appointments. House Bill 2060 does not clarify if the participating localities approve only their own jurisdiction's appointees, or if one jurisdiction has the power to approve ALL appointments made to the Board of Directors. Case in point, our largest jurisdiction mandated that they receive, in writing, notification from the other two jurisdictions, their choices for board appointees. One jurisdiction refused to do so, and our largest jurisdiction stated that the Health Partnership Authority Board was not allowed to meet, until after *they approved* the other jurisdictions' appointees.

4. Our funding streams are limited to applications made to the federal or state governments only, due to a restriction added to the by-laws by our local jurisdictions. This restriction states that, "the Health Partnership, or its agents, may not now, or in the future, request local tax support or impose financial liability on local jurisdictions." Whereas, the legislation provides for the opportunity for the local health partnership authorities to receive funding from local governments, our participating localities precluded us from having the benefit/opportunity to do so. If the legislation clarified that it has the "final say" or

power regarding funding sources, it would help local communities be eligible for a multitude of revenue sources and opportunities, that our area is not eligible for due to the locally-imposed restrictions.

To overcome this hurdle, our organization applied to a non-stock corporation, so that we could file for 501(c)3 status. This organization acts as a "holding company" for the Authority so that funding received would be tax-exempted and kept "safe" from being distributed to the other jurisdictions, should our organization be dissolved. By creating a non-stock (not-for-profit) organization, we can assure citizens, businesses and private entities (foundations, etc.) that the funding given to improve the health and well being of Greater Prince William stays available to accomplish such goals.

**Two additional notes:**

- Because this is a pilot project and a "sunset clause" exists, to date we have been denied eligibility for Federal funding.

- The Commonwealth of Virginia will not permit the use of the words "Partnership" or "Authority" in a title of a corporation. Thus, our organization's corporation is entitled "Prince William Health Partners, Inc." It is this entity, that has applied for tax-exempt status, specifically to become a 501(c)3 organization, in order to be eligible for grant applications to private foundations.

**What We Have Done So Far (Time line of Activities Completed):**

- In September 2001, the Resolutions were passed in the jurisdictions of Prince William County, the City of Manassas, and the City of Manassas Park
- In October 2001, the process began for suggestions of citizens and focus-area representatives' names for collection from the three jurisdictions
- In October 2001, the original draft was written of the By-Laws for review by the jurisdictions
- Prepared final draft of by-laws for review by jurisdiction(s) in November 2001
- Submitted candidate names as nominations for Board Appointments to jurisdictions for review in November 2001
- In December, began interview process for an Executive Director of the Authority
- Met with largest jurisdiction to discuss changes made to by-laws by their office in December
- Made recommended revisions to the by-laws and resubmitted draft to jurisdiction in December 2001
- Hired Executive Director in January 2002
- Received additional revisions to the by-laws from jurisdiction, made appropriate adjustments and resubmitted draft of by-laws in January 2002
- Received confirmation of Board Appointment from one jurisdiction

- In February 2002, the Authority's staff began researching grant and other funding opportunities
- Met again with largest jurisdiction, in February 2002, to discuss additional changes made by jurisdiction to by-laws
- March 2002, last formal meeting held of original health partnership committee
- March 2002, final versions of the Authority's By-Laws and Articles of Incorporation were approved by Prince William County and the City of Manassas Park
- March 2002, received Board Appointee confirmations from Prince William County and City of Manassas Park
- April 2002, received approval from City of Manassas for the Authority's By-Laws and Articles of Incorporation
- May 2002, received Board Appointee confirmations from City of Manassas
- May 15, 2002, held first Prince William Health Partnership Authority Board Meeting
- June 2002, received additional Board Appointee confirmation from City of Manassas
- June 2002, made first grant application to Health & Human Service's Center for Disease Control (CDC)
- June 2002, invited to attend Community Health Governance conference in Seattle Washington. Presented on the purpose, objectives, goals and status of the Authority
- June 2002, held second Board meeting
- July 2002, contacted by the CDC regarding grant application. Notified that were declining our application, because the question the longevity and validity of the Authority due to legislation deadline clause provision
- July 2002, held third Board meeting
- August 2002, made second grant application to Robert Wood Johnson Foundation
- August 2002, held social gathering for Board members (a "get-to-know-each-other" event)
- August 2002 held day-long Board Retreat
- August 2002, made third grant application to Virginia Health Care Foundation

## 2002 PWHPA Board Directors:

**Focus-Area Representation:**

-Locally-Elected Official– Mrs. Hilda Barg, County Supervisor, Woodbridge District

-Health Care Representative–-Mr. William M. Moss, President, Potomac Hospital

-Business Community Representative—Mrs. Janet Lewis, Prince William Chamber of Commerce

-Non-Profit, Non-Governmental Human Services Representatives (3):

(PW)—Mrs. Karen Smith, ARC; (M)—Mrs. Barbara DeChene, NVFS; (MP)—Mr. Andrew Byrd, Caton Merchant House

**Citizen Representatives:**

| | |
|---|---|
| Chris Caseman (PW) | Paul Gibson (M) |
| Owen Lewis (PW) | Ervinia (Venus) Miller (PW) |
| Paul Moessner (PW) | Indira (Indy) Moran (PW) |
| Dorinda Pearson (M) | Noreen Slater (MP) |
| Bill Ward (M) | |

Note: (PW)=Prince William (M)=Manassas (MP)=Manassas Park

## PWHPA Strategic Planning Report

September 2002

**Purpose of PWHPA**:

- Is to guide, support and coordinate the delivery of health-related services through on-going community assessment and priority setting.
- Through this centralized coordination, PWHPA will minimize duplication of effort and ensure that area health and community services are more accessible to every*body* in need.

**Mission Statement**

The mission of the Health Partnership Authority (PWHPA) is to develop and assist partnerships among the public and community non-profit providers. We will assist in

planning, sharing resources, reducing barriers and implementing strategies to address the health care needs and improve the quality and availability of health care in the Prince William area.

**Vision Statement**

The vision of the Prince William Health Partnership Authority is to foster, through a variety of creative and inclusive partnerships, healthier communities within the Prince William area through increased awareness, accessibility and affordability.

**Priorities Set for Greater Prince William for Years 2002 through 2005:**

The priorities we have set are centered on addressing these areas with a focus on two main themes:

> ***"Waist Management":*** Program to curb obesity and individuals becoming overweight within the Greater Prince William population. The Greater Prince William area has the highest proportion of individuals who are overweight and obese, more than any other region in the Greater Washington Metropolitan Region (region comprised of: Maryland's Fredrick, Montgomery & Prince George's Counties; Virginia's Alexandria, Arlington, Fairfax, Loudoun and Prince William Counties, and the District of Columbia.) The Prince William Health Partnership Authority has chosen this initiative as a priority because of the numerous complications and the development of disease-related conditions due to being overweight and obese. For instance, obesity is the second leading cause of preventable death in the United States. The costs of treating adults with obesity are over $238 billion a year, making it one of the most expensive diseases in the country. It is increasing among all age, gender, racial and ethnic groups, both in the United States and around the world.
>
> Furthermore, according the American Obesity Association website, "Persons with obesity are at risk of developing one or more serious medical conditions, which can cause poor health and premature death. Obesity is associated with more than 30 medical conditions, and scientific evidence has established a strong relationship with at least 15 of those conditions. Preliminary data also show the impact of obesity on various other conditions. Weight loss of about 10% of body weight, for persons with overweight or obesity, can improve some obesity-related medical conditions including diabetes and hypertension." *Text taken from American Obesity Association Website, on Health Effects of Obesity.*
>
> The Authority will focus on this initiative by increasing awareness, providing greater community education, and by creating partnership programs.

**Awareness and Education Initiatives**

- Work with area Primary Care Physicians (PCP), to encourage the adoption of more patient/doctor interaction regarding steps, activities, referrals and educational information at time of visit. Also, encourage procedures for communicating to patient early detection and preventive measures.

- Work with community organizations (schools, churches, retail outlets, etc.) to help spread "Waist Management" information. This can be done through highly visible public events, and/or through consistent information publication about the health effects of being overweight/obese.

**Program Partnership Initiatives**

- Employer Relations Program—form collaborative/partnership programs with Employers within Greater Prince William to encourage healthier lifestyles (specifically related to diet, exercise, and disease management) for employees. Initiative will focus on prevention and workplace reward as incentive.

- Healthy Heroes Program—form partnership program with firefighters, policemen, paramedics, and local athletes to be models for developing fitness/health initiatives for children and adults to participate in as "Community Challenges."

- The Melting Pot Program—targeting sub-populations with culturally appropriate health and weight information through community organizations and outreach initiatives. (Initiatives may include healthy cooking classes, educational outreach at grocery markets and fitness activities at community organizations like churches, schools, etc.)

***"Healthy Children for a Healthy Future":*** Program initiative to promote overall health and wellness of our children. As the title states, this was set as a priority because we believe our children are our future. Initiative will seek opportunities to improve the overall health of Greater Prince William children. The focus will be on preventative measures, as well as opportunities to further enhance quality and scope of services being currently utilized.

## PWHPA Strategic Planning-Community Relations

| **AUDIENCE:** With whom do we want to interact? | **PUBLIC SEGMENTS:** Who are the specific target groups? | **RELATIVE IMPORTANCE:** (1=High; 5=Low) |
|---|---|---|
| **AUDIENCE:** With whom do we want to interact? | **PUBLIC SEGMENTS:** Who are the specific target groups? | **RELATIVE IMPORTANCE:** (1=High; 5=Low) |
| Funders | 1. Foundations<br>2. Businesses<br>3. Federal Government<br>4. Individual Donors | 1. Foundations= 1<br>2. Businesses= 2<br>3. Federal Government= 2<br>4. Individual Donors= 5 |
| Community Organizations/ Partners | 1. Health Service Providers<br>2. Human Service Providers<br>3. Churches<br>4. Schools<br>5. Neighborhoods<br>6. Employers<br>7. Local government agencies<br>8. Other service-type providers (retailers, etc.) | 1. Health Service Providers=1<br>2. Human Service Providers=1<br>3. Churches=2<br>4. Schools=2<br>5. Neighborhoods=5<br>6. Employers=3<br>7. Local govt. agencies=3<br>8. Other service providers=4 |
| Medically Underserved Population | 1. Low income<br>2. Uninsured and/or Under Insured<br>3. Those with Limited Access (includes, but not limited to: awareness/education; transportation; limited income; Illiterate; etc.)<br>4. Minorities<br>5. Adults with Health Concerns<br>6. Children/Families w/ Health Concerns | 1. Low Income=1<br>2. Uninsured/Under Insured=1<br>3. Those with Limited Access=1<br>4. Minorities=1<br>5. Adults with health concerns=1<br>6. Children/Families with health concerns=1 |
| Public Opinion Makers | 1. Media Editorialists<br>2. Community Reporters (Newspaper; TV; Radio)<br>3. Public Officials<br>4. Community Leaders | 1. Media Editorialists=3<br>2. Community Reporters=1<br>3. Public Officials=2<br>4. Community Leaders=2 |

| | | |
|---|---|---|
| General Public | 1. Citizens of Manassas City<br>2. Citizens of Manassas Park City<br>3. Citizens of Prince William County<br>4. Employers<br>5. Community Agencies | 1. Citizens of Manassas=1<br>2. Citizens of Manassas Park=1<br>3. Citizens of Prince William County=1<br>4. Employers=3 |
| Volunteers | 1. Partnering Organization Workers<br>2. Concerned Citizens<br>3. Community Leaders | 1. Partnering Org. Workers=1<br>2. Concerned Citizens=2<br>3. Community Leaders=2 |

| PWHPA Strategic Planning | |
|---|---|
| **OBJECTIVE** | **TARGET DATE / TIMELINE FOR ACTION** |
| **A. Planning and Preparation**<br>1. Develop Strategic Plan for Year 2002-04<br>2. Develop Marketing/Communication Plan<br>3. Develop Committee to Support Progress | 1. Complete by September 30, 2002<br>2. Complete by October 2, 2002<br>3. In process (two committees formed, more to follow on per need basis only) |
| **B. Board Relations / Development**<br>1. Hold Social Gathering as Board Relationship Builder<br>2. Hold Board Retreat with Facilitator | 1. Done, social occasion big success; fostered relationship building among members. (8/23/02)<br>2. Completed. Productive and successful. (8/24/02) |
| C. Program Development<br>1. Set Priorities for project/program initiatives<br>2. Determine Program Scope<br>3. Identify Partners<br>4. Secure Funding | 1. Completed. Two priorities set for Years 2002-2004 Program Initiatives also set: 1) "Waist Management" -program to decrease # of citizens who are obese or overweight, see attachment. 2) "Healthy Children for a Healthy Future"- initiative to promote health and well being of children in Greater Prince William, see attachment.)<br>2. In process, finalization of scope will be completed by October 31, 2002.<br>3. In process, target date for completion, November 30, 2002.<br>4. In process and on going. Target date: receive first round of new funding by June 2003. |
| **D. Implement Programs**<br>1. "Waist Management" | 1. Will be in three phases: communication/ awareness-target date to begin Nov. 2002; program activities & events-target date to begin June 2003; evaluation & next steps- |

| | |
|---|---|
| 2. "Healthy Children for a Healthy Future" | June 2004.<br><br>2. Will be in communication/ awareness-target date to begin March 2003; program activities & events-target date to begin August 2003; evaluation & next steps-August 2004 |

## PWHPA Message "The Who, What and How"

| Public Segment | The Information: What Do We Want Them to Know or Do? | The Message: What Should We Tell Them? |
|---|---|---|
| 1. Funders | 1. We want their funding/ support.<br>2. To know that we are a viable program.<br>3. To know why we are unique and how this "uniqueness" can benefit the community in ways previously not done. | 1. One specific program initiative per funder.<br>2. Explain our "uniqueness"<br>3. Outline objectives, goals and projected outcomes<br>4. How the funding/support will be used and why this is beneficial for OUR community. |
| 2. Community Organizations/Partners | 1. We want their ACTIVE program participation.<br>2. WHY we are doing a particular program initiative. (Community needs, info, etc.)<br>3. What could be gained by their participation.<br>4. How the community will benefit from THEIR participation in the initiative. | 1. What specifically we want them to do (their 'duties' and role in program); the time and commitment we are seeking from them.<br>2. Share evidence of why it is a community need and what will happen if not addressed.<br>3. Projected outcome by having their participation.<br>4. Overall goal(s) and outcome(s) expected. |
| 3. Medically Underserved Population | 1. We want them to participate in our program initiative and become healthier.<br>2. We want them to integrate healthy lifestyles, behaviors and choices into their daily practices.<br>3. We want to create a | 1. Why we want their participation (why this initiative is important and how it could impact their lives.<br>2. How the can participate and how there are resources to support the transition to healthy lifestyles. |

| | | |
|---|---|---|
| | HEALTHIER GPW. | 3. Why it is important that we create a Healthier GPW---impact also on all taxpayers lives, if not properly addressed. |
| 4. Public Opinion Makers | 1. We want them to know that we exist and demonstrate public support for our entity and program initiatives.<br><br>2. We want them to be a source of information dissemination (from us) to the General Public. (Open line/communication stream on an on-going basis. Get their "buy-in.") | 1. Explain our "uniqueness" and how the community can benefit by having such an organization in GPW.<br>2. Outline our program initiative(s), the purpose of program, why our community needs it, what the goals are, the benefit to the community and the projected outcome/positive efforts for GPW. |
| General Public | 1. Same as Medically Underserved Population (see above) | |
| Volunteers | 1. Same as Community Organizations/Partners | |

# IV.
# Evaluation of the
# Prince William Health Partnership Authority

PWHPA experienced a number of delays in organizing that resulted in part from being the pilot for the local health partnership concept. Other delays seemed to be consistent with the experience of many multi-jurisdictional organizations when they initially begin to work together.

A number of important lessons were learned through PWHPA's experience. PWHPA found in some instances, that the language contained in *Code of Virginia* § 32.1-122.10:001 was overly prescriptive. For example, the requirement that each participating locality have one Board member who represents a "non-profit, non-governmental, human services agency" was problematic because one locality did not have an agency that met that requirement. This type of requirement is likely to be difficult for other areas of Virginia to accommodate. PWHPA found that in other instances, the statutory language was not prescriptive enough resulting in delays while the jurisdictions worked out an agreement. An example of this included disagreement over whether a participating locality is empowered to approve the Board appointees of the other participating localities. If additional partnerships are envisioned, the experience of PWHPA should be considered in amending *Code of Virginia* § 32.1-122.10:001.

Considering PWHPA's stage of development, no assessment could be made of the Authority's ability to secure funding for programs and to carry out those programs. PWHPA seems to be ready to initiate its planned programs. PWHPA has the support of local government officials and community organizations in Prince William County and the cities of Manassas and Manassas Park. However, the sunset date of July 1, 2003 serves as a significant barrier to initiating programs.

It is difficult at this juncture to make any judgments regarding the advisability of allowing for additional local health partnership authorities. In order to facilitate making such a judgment, the Joint Commission on Health Care may wish to require PWHPA to submit ongoing reports if the sunset date for its existence is changed or removed.

# V.
# Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to recommend with regard to the local health partnership authority in Planning District 8.

**Option I:** **Take no action (which would allow the legislation to sunset effective July 1, 2003).**

**Option II:** **Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to extend the sunset date to July 1, 2006.**

**Option III:** **Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to remove the sunset clause.**

**Option IV:** **Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to require biennial reports by the Prince William Health Partnership Authority to the Joint Commission on Health Care.**

# Appendix A:

## House Bill 2060
## 2001 General Assembly Session

# CHAPTER 671

*An Act to amend and reenact § 32.1-127.1:03 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 6.1, consisting of sections numbered 32.1-122.10:001 through 32.1-122.10:005, relating to local health partnership authorities.*

[H 2060]
Approved March 25, 2001

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127.1:03 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 6.1, consisting of sections numbered 32.1-122.10:001 through 32.1-122.10:005, as follows:

*Article 6.1.*
*Local Health Partnership Authorities.*

*§ 32.1-122.10:001. Purpose; one or more localities may create authority; advertisement and notice of hearing; pilot program; evaluation.*

*A. Communities lack the ability to coordinate, across jurisdictions, health partnership efforts between local governments and private providers of health care services, which leads to duplicative and inefficient services. Such public/private partnerships could (i) encourage the use of service delivery that otherwise might have required government funding or programs; (ii) allow governments to fully participate in such partnerships; (iii) maximize the willingness of individuals, agencies and private organizations to lend their expertise to help satisfy community needs; (iv) allow innovative funding mechanisms to leverage public funds; (v) allow appropriate information sharing to ensure the adequacy and quality of services delivered; (vi) provide liability protection for volunteers providing services under programs sponsored or approved by the authority; (vii) provide a mechanism to ensure that services provided in the community are necessary, appropriate, and provided by trained and supervised persons; and (viii) allow volunteers and others to focus their energies to achieve community health improvement. Health care services include, but are not limited to, treatment of and education about acute and chronic diseases, wellness and prevention activities that promote the health of communities, and access to services and activities.*

*B. The governing body of a locality may by ordinance or resolution, or the governing bodies of two or more localities may by concurrent ordinances or resolutions or by agreement, create a local health partnership authority which shall have as its purpose developing partnerships between public and private providers. The name of the authority shall contain the word "authority." The ordinance, resolution or agreement creating the authority shall not be adopted or approved until a public hearing has been held on the question of its adoption or approval. The authority shall be a public body politic and corporate.*

*C. The governing body of each participating locality shall cause to be advertised at least one time in a newspaper of general circulation in such locality a copy of the ordinance, resolution or agreement creating the authority, or a descriptive summary of the ordinance, resolution or agreement and a reference to the place where a copy of such ordinance, resolution or agreement can be obtained, and notice of the day, not less than thirty days after publication of the advertisement, on which a public hearing will be held on the ordinance, resolution or agreement.*

*D. To ensure that such authorities operate in an efficient manner and are accomplishing the goals set for them, a pilot project shall be instituted in Planning District 8 in a community health program that has been operating under the auspices of the Robert Wood Johnson and the Kellogg Foundations. The Joint Commission on Health Care shall monitor and provide technical advice to the authority and shall, by November 15, 2002, evaluate the program and make recommendations as to continuation of such an authority, the expansion to other areas of the state, and changes, if any, that are necessary to improve the program.*

*E. No authority created pursuant to this article shall be exempt from any of the provisions of the Certificate of Public Need laws and regulations of the Commonwealth.*

*F. No authority created pursuant to this article shall be allowed to issue bonds or other form of indebtedness.*

*§ 32.1-122.10:002. Board of directors; expenses; officers; terms of office; quorum; annual report.*

*A. All powers, rights and duties conferred by this article, or other provisions of law, upon an authority shall be exercised by a board of directors. The participating localities in the local health partnership authority shall determine the composition of the membership of the board. At a minimum, the board shall be composed of one locally elected official, one representative of the health care industry, one representative of the business community, and one representative of the nongovernmental human services agencies from each participating locality; and, sufficient citizen members to constitute the majority of the board, who shall not be employed by, nor board members of, nor financially linked to the partnering agencies, groups and corporations involved.*

*B. Each member of a board shall serve for a term of four years and may serve no more than two consecutive full terms. The creation of a vacancy on the board shall be filled in the same manner by the appointing locality, such position being filled for the unexpired term.*

*C. Members of the board of directors shall be reimbursed for actual expenses incurred in the performance of their duties from funds available to the board and according to policy determined by the board.*

*D. Each board shall elect from its membership a chairman, vice chairman and secretary/treasurer. The board shall appoint an executive director who shall discharge such functions as may be directed by the board. The authority shall employ such staff as*

*may be appropriate to coordinate the work of the participating organizations in support of programs and services approved by each board. The executive director and staff shall be paid from funds received by the authority.*

*E. Each board, promptly following the close of the fiscal year, shall submit an annual report of the authority's activities of the preceding year to the governing body of each member locality and to the Joint Commission on Health Care. Each such report shall set forth a complete operating and financial statement covering the operation of the authority during such year.*

*§ 32.1-122.10:003. Office of the authority.*

*The board of each authority shall establish a principal office within one of the participating jurisdictions. The title to all property of every kind belonging to the authority shall be titled to the authority for the benefit of all of its members.*

*§ 32.1-122.10:004. Powers of the authority.*

*Any authority shall have the following powers:*

*1. Each authority is vested with the powers of a body corporate, including the power to sue and be sued in its own name, to adopt and use a common seal and to alter the same as may be deemed expedient, to make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the authority, and to make, amend or repeal bylaws, rules and regulations, not inconsistent with law, to carry into effect the powers and purposes of the authority.*

*2. To foster and stimulate the cooperative assessment and provision of health care in the community by local governments, private entities and volunteers.*

*3. To cooperate with local and state health care planning entities, and local, state or federal governments in the discharge of its duties.*

*4. To solicit and accept grants or donations from local, state or federal governments or any instrumentality thereof, private entities, or any other source, public or private, for or in aid of any project of the authority to provide health services as defined in subsection A of § 32.1-122.10:001.*

*5. To do any and all other acts and things that may be reasonably necessary and convenient to carry out its purposes and powers.*

*§ 32.1-122.10:005. Licensed agents; liability.*

*No volunteer of any participating entity who is duly licensed to provide health care services shall be liable for any civil damages for any act or omission resulting from the rendering of such services to a recipient of a program designated by the authority when such services are provided without charge and within the scope of the volunteer's authority to practice and the volunteer delivering such services has no legal or financial interest in the program to which the patient is referred, unless such act or omission was*

*the result of gross negligence or willful misconduct. The provisions of this section shall apply only to noninvasive and minimally invasive procedures limited to finger sticks and injections performed as part of health care services. The provisions of this subsection shall apply to those appropriate volunteers providing care during the time in which such care is rendered free of charge.*

§ 32.1-127.1:03. Patient health records privacy.

A. There is hereby recognized a patient's right of privacy in the content of a patient's medical record. Patient records are the property of the provider maintaining them, and, except when permitted by this section or by another provision of state or federal law, no provider, or other person working in a health care setting, may disclose the records of a patient.

Patient records shall not be removed from the premises where they are maintained without the approval of the provider, except in accordance with a court order or subpoena consistent with § 8.01-413 C or with this section or in accordance with the regulations relating to change of ownership of patient records promulgated by a health regulatory board established in Title 54.1.

No person to whom disclosure of patient records was made by a patient or a provider shall redisclose or otherwise reveal the records of a patient, beyond the purpose for which such disclosure was made, without first obtaining the patient's specific consent to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any provider who receives records from another provider from making subsequent disclosures as permitted under this section or (ii) any provider from furnishing records and aggregate or other data, from which patient-identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as a patient's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Guardian" means a court-appointed guardian of the person.

"Health services" includes, but is not limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind.

"Parent" means a biological, adoptive or foster parent.

"Patient" means a person who is receiving or has received health services from a provider.

"Patient-identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual patient.

"Provider" shall have the same meaning as set forth in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered providers for the purposes of this section. Provider shall also include all persons who are licensed, certified, registered or permitted by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Record" means any written, printed or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to the patient.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act; or

2. Except where specifically provided herein, the records of minor patients.

D. Providers may disclose the records of a patient:

1. As set forth in subsection E of this section, pursuant to the written consent of the patient or in the case of a minor patient, his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; also, in emergency cases or situations where it is impractical to obtain the patient's written consent, pursuant to the patient's oral consent for a provider to discuss the patient's records with a third party specified by the patient;

2. In compliance with a subpoena issued in accord with subsection H of this section, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a provider or the provider's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a provider's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by any other provision of law including contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2403.3, 54.1-2906, 54.1-2907, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.1-55.3 and 63.1-248.11;

7. Where necessary in connection with the care of the patient, including in the implementation of a hospital routine contact process;

8. In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412;

9. When the patient has waived his right to the privacy of the medical records;

10. When examination and evaluation of a patient are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such;

11. To the guardian ad litem in the course of a guardianship proceeding of an adult patient authorized under §§ 37.1-128.1, 37.1-128.2 and 37.1-132;

12. To the attorney appointed by the court to represent a patient in a civil commitment proceeding under § 37.1-67.3;

13. To the attorney and/or guardian ad litem of a minor patient who represents such minor in any judicial or administrative proceeding, provided that the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the provider of such order;

14. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's records in accord with § 9-173.12;

15. To an agent appointed under a patient's power of attorney or to an agent or decision maker designated in a patient's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

16. To third-party payors and their agents for purposes of reimbursement;

17. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided;

18. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

19. In accord with § 54.1-2400.1 B, to communicate a patient's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

20. To the patient, except as provided in subsections E and F of this section and subsection B of § 8.01-413;

21. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

22. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

23. If the records are those of a deceased or mentally incapacitated patient to the personal representative or executor of the deceased patient or the legal guardian or committee of the incompetent or incapacitated patient or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased patient in order of blood relationship;

24. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks; ~~and~~

25. To the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services pursuant to Chapter 55 (§ 2.1-815 et seq.) of Title 2.1*; and*

*26. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of Title 32.1, pursuant to subdivision D 1 of this section.*

E. Requests for copies of medical records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The provider shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within fifteen days of receipt of a request for copies of medical records, the provider shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the provider does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the provider who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such records or proof of his identity, or (c) as

otherwise provided by law. Procedures set forth in this section shall apply only to requests for records not specifically governed by other provisions of this Code, federal law or state or federal regulation.

F. Except as provided in subsection B of § 8.01-413, copies of a patient's records shall not be furnished to such patient or anyone authorized to act on the patient's behalf where the patient's attending physician or the patient's clinical psychologist has made a part of the patient's record a written statement that, in his opinion, the furnishing to or review by the patient of such records would be injurious to the patient's health or well-being. If any custodian of medical records denies a request for copies of records based on such statement, the custodian shall permit examination and copying of the medical record by another such physician or clinical psychologist selected by the patient, whose licensure, training and experience relative to the patient's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The person or entity denying the request shall inform the patient of the patient's right to select another reviewing physician or clinical psychologist under this subsection who shall make a judgment as to whether to make the record available to the patient. Any record copied for review by the physician or clinical psychologist selected by the patient shall be accompanied by a statement from the custodian of the record that the patient's attending physician or clinical psychologist determined that the patient's review of his record would be injurious to the patient's health or well-being.

G. A written consent to allow release of patient records may, but need not, be in the following form:

CONSENT TO RELEASE OF CONFIDENTIAL HEALTH CARE

INFORMATION

Patient Name.....
Provider Name.....
Person, agency or provider to whom disclosure is to be made.....
Information or Records to be disclosed.....

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires on (date).....

Signature of Patient..... Date .....

H. 1. No party to an action shall request the issuance of a subpoena duces tecum for an opposing party's medical records or cause a subpoena duces tecum to be issued by an

attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to opposing counsel or the opposing party if they are pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action shall request or cause the issuance of a subpoena duces tecum for the medical records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

In instances where medical records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

**NOTICE TO PATIENT**

**The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor or other health care providers (names of health care providers inserted here) requiring them to produce your medical records. Your doctor or other health care provider is required to respond by providing a copy of your medical records. If you believe your records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court to quash the subpoena. You may contact the clerk's office to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, it must be filed as soon as possible before the provider sends out the records in response to the subpoena. If you elect to file a motion to quash, you must notify your doctor or other health care provider(s) that you are filing the motion so that the provider knows to send the records to the clerk of court in a sealed envelope or package for safekeeping while your motion is decided.**

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for a patient's medical records shall include a Notice to Providers in the same part of the request where the provider is directed where and when to return the records. Such notice shall be in boldface capital letters and shall include the following language:

**NOTICE TO PROVIDERS**

**IF YOU RECEIVE NOTICE THAT YOUR PATIENT HAS FILED A MOTION TO QUASH (OBJECTING TO) THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, SEND THE RECORDS ONLY TO THE CLERK OF THE COURT WHICH ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE: PLACE THE RECORDS IN A SEALED**

**ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT WHICH STATES THAT CONFIDENTIAL HEALTH CARE RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING THE COURT'S RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT.**

3. Health care providers shall provide a copy of all records as required by a subpoena duces tecum or court order for such medical records. If the health care provider has, however, actual receipt of notice that a motion to quash the subpoena has been filed or if the health care provider files a motion to quash the subpoena for medical records, then the health care provider shall produce the records to the clerk of the court issuing the subpoena or in whose court the action is pending, where the court shall place the records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge. In the event the court grants the motion to quash, the records shall be returned to the health care provider in the same sealed envelope in which they were delivered to the court. In the event that a judge orders the sealed envelope to be opened to review the records in camera, a copy of the judge's order shall accompany any records returned to the provider. The records returned to the provider shall be in a securely sealed envelope.

4. It is the duty of any party requesting a subpoena duces tecum for medical records or the attorney issuing the subpoena duces tecum to determine whether the patient whose records are sought is pro se or a nonparty. Any request for a subpoena duces tecum and any attorney-issued subpoena for the medical records of a nonparty or of a pro se party shall direct the provider (in boldface type) not to produce the records until ten days after the date on which the provider is served with the subpoena duces tecum and shall be produced no later than twenty days after the date of such service.

In the event that the individual whose records are being sought files a motion to quash the subpoena, the court shall decide whether good cause has been shown by the discovering party to compel disclosure of the patient's private records over the patient's objections. In determining whether good cause has been shown, the court shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

The provisions of this subsection have no application to subpoenas for medical records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a provider's conduct. The provisions of this subsection apply to the medical records of both minors and adults.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

Providers may testify about the medical records of a patient in compliance with §§ 8.01-399 and 8.01-400.2.

2. That the provisions of this act shall expire on July 1, 2003.

# Appendix B:

# Summary of Public Comments

# JOINT COMMISSION ON HEALTH CARE

## SUMMARY OF PUBLIC COMMENTS:
## Prince William Health Partnership Authority

### Organizations/Individuals Submitting Comments

Eight persons/organizations submitted comments in response to the Prince William Health Partnership Authority study:

- Chris E. Caseman
- Beth Gibson
- Margarita F. Gibson
- Paul S. Gibson
- Janet Lewis
- Owen Lewis
- Ervinia (Venus) Lewis
- Paul C. Moessner

### Policy Options Included in the Issue Brief Prince William Health Partnership Authority

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to recommend with regard to the local health partnership authority in Planning District 8.

**Option I:** **Take no action (which would allow the legislation to sunset effective July 1, 2003).**

**Option II:** **Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to extend the sunset date to July 1, 2006.**

| | |
|---|---|
| **Option III:** | **Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to remove the sunset clause.** |
| **Option IV:** | **Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to require biennial reports by the Prince William Health Partnership Authority to the Joint Commission on Health Care.** |

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**Overall Summary of Comments**

Overall, the eight commenters supported Option III as their first or only choice. Four of the eight commenters indicated that Option II would be supported if the Joint Commission does not recommend Option III.

In addition, both Delegate McQuigg and Delegate Parrish, patrons of HB 2060 indicated their support for Option III to remove the sunset clause.

**Summary of Individual Comments**

**Chris E. Caseman**

Chris E. Caseman, "Citizen Representative", Chair of the Prince William Health Partnership Authority, stated:

> "The purpose of this letter is to express my strong support for the Authority and the tremendous positive impact it will ultimately have on the citizens of the greater Prince William Area. I would also like to express my sincere appreciation to the State Legislature for the enactment of the legislation that created the Authority....There is however one area of the existing legislation that I believe needs modified to provide the Authority the necessary time to meet the broad list of objectives we've established. Specifically, the Legislation contains a "sunset" provision which can be implemented at discretion of the Legislature following one year of the Authority's existence....
>
> The sunset provision hinders the effectiveness in several ways. For example, we need to be able to demonstrate to the community our long term commitment for dramatically improving health. The very fact that we could be dissolved only after one year of existence will not be very reassuring to the community. Secondly, applying for funding is significantly more difficult as revenue sources are not likely to fund an organization that could be so readily dissolved. Therefore, I respectfully

request removal of the sunset provision. However, if the Legislature is unwilling to remove the sunset provision entirely, my hope is that the Authority will be granted minimum period of 3 years of existence to accomplish many of the programs/improvement for community health we envision."

**Beth Gibson**

Beth Gibson, resident of the City of Manassas, stated, "I strongly support keeping the Prince William Health Partnership Authority in place and want to see it continue for the future."

**Margarita F. Gibson**

Margarita F. Gibson, resident of the City of Manassas, stated, "I strongly support keeping the Prince William Health Partnership Authority in place and want to see it continue for the future."

**Paul S. Gibson**

Paul S. Gibson, resident of the City of Manassas, stated, "I strongly support keeping the Prince William Health Partnership Authority in place and want to see it continue for the future, for as long as it needs to in order to measurably improve community health in the Prince William area."

**Janet Lewis**

Janet Lewis stated:

"I am in support of introducing legislation ...to remove the sunset clause. As a Business Representative appointed in March 2002 to the Board of the Prince William Health Partnership Authority, I think removal of the sunset clause will be vital to the success of the Authority, especially as funding is sought and for credibility that the Authority is not a short term solution to long term community health issues.

Removal of the statute allows partnerships among businesses, public and private entities to work to solve community health issues through joint efforts and programs. These partnerships are in a position to seek and provide resources for community health programs avoiding the need to see government funding for programs to meet those community health needs. Volunteers among the participating partnerships, who are licensed to provide health care, need liability protection. The Authority provides

liability protections for those volunteers – a critical issue for them and for those who want and need their services.

As a last resort, if removing the sunset clause is not possible...I would favor introducing legislation to amend Code of Virginia 32.1-122.10.001 to extend the sunset date at least to July 1, 2006 - or beyond."

**Owen Lewis**

Owen Lewis, "Citizen Representative" from Prince William County on the Prince William Health Partnership Authority, concurred with the comments submitted by Chris E. Caseman.

**Ervinia (Venus) Miller**

Ervinia (Venus) Miller, "Citizen Representative" from Prince William County on the Prince William Health Partnership Authority, stated:

"... I respectfully request that our pilot project be granted the provision of making the "sunset" go-away. By doing so, it will demonstrate to our community that we have a vested interest in improving the health of Greater Prince William, and that we are steadfast in our commitment to creating a healthier community for everyone. If for some reason, you decide that you cannot give us this provision at this time, then I respectfully request as a second option that the Virginia General Assembly grant our organization a three-year extension."

**Paul C. Moessner**

Paul C. Moessner, resident of Prince William County, stated:

"I would very much appreciate the JCHC's assistance in extending the legislative mandate to allow local bodies such as PWHPA to remain in place and functioning. Further, I believe that the substantive progress of PWHPA would warrant amendment of the enabling legislation to set aside the sunset provision of HB 2060."

# JOINT COMMISSION ON HEALTH CARE

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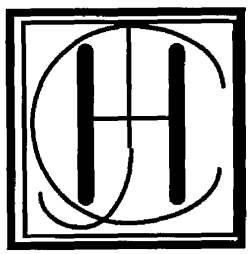

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